

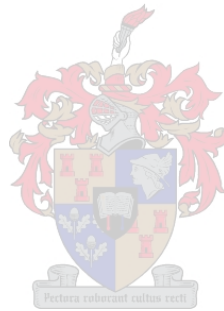
Moral Responsibility for Prenatal Harm to Children: The Case of Fetal Alcohol Syndrome

Jillian Gardner

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Supervisor: Prof AA van Niekerk

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Declaration

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Summary

This dissertation deals with the problem of Fetal Alcohol Syndrome (FAS) and the moral responsibility of pregnant women who carry fetuses to term, as well as the rest of society, to try and prevent children from suffering from this condition.

From the perspective of behaviour, most pregnant women who plan to carry a fetus to term, act in ways that are conducive to the normal development and welfare of their future children. With the intent to deliver a normal, healthy birth baby, a pregnant woman will alter her lifestyle accordingly. On the other hand, some pregnant women behave in ways that are not conducive to the birth of normal healthy children.

Drinking during pregnancy is associated with a range of negative pregnancy outcomes including spontaneous abortion, breech presentations, fetal growth retardation and premature delivery. A range of disorders and disabilities can occur in varying degrees in the child exposed to alcohol prenatally. Fetal alcohol syndrome (FAS) is the most severe diagnosable condition, along a spectrum of disorders, collectively termed fetal alcohol spectrum disorders (FASD) that can occur in children who were exposed to alcohol prenatally. In the Western world, FAS is a leading preventable cause of mental retardation (Hackler 2011). It is a major public health issue in countries where alcohol is widely used.

There is no cure for FAS. Affected individuals suffer a range of permanent primary and secondary disabilities. Surgery can repair some of the physical problems and services can be made available to improve mental and physical development so that children may lead relatively normal lives, but they remain below average in physical and mental development throughout their lives. FAS and its associated social and

economic costs can be avoided if a woman abstains from alcohol for the duration of her pregnancy.

This dissertation firstly sets out to establish whether and what moral obligations pregnant women who choose to continue their pregnancies (i.e. prospective mothers) may have towards their future children. I argue that women choose to continue a pregnancy when they have the option of terminating their pregnancies and that they are prospective mothers when they do so, to distinguish them from pregnant women who choose to terminate their pregnancies. I argue that prospective mothers, even those who are alcoholics, have *prima facie* moral obligations to benefit and not to harm their future children and, can be held morally responsible for their actions.

Having considered a prospective mother's moral responsibility for drinking during pregnancy, I then investigate society's interest in these issues. I argue that even though women have primary responsibility for FAS prevention, that they are not solely responsible for it. I offer reasons why punitive approaches are undesirable, and propose what I consider to constitute an ethically appropriate social response to prevent FAS. Finally, I consider whether children with FAS can and should be allowed to sue their mothers for damages under South African law. I argue that even though children can theoretically sue their mothers for damages that this too may be ineffective at preventing FAS.

Opsomming

Hierdie proefskrif handel oor die probleem van Fetale Alkoholsindroom (FAS) en die morele verantwoordelikheid van swanger vroue om te probeer verhoed dat hul kinders aan hierdie toestand ly.

Vanuit die perspektief van menslike gedrag tree die meeste swanger vroue wat beoog om aan hul fetusse geboorte te skenk op op maniere wat bevorderlik is vir die normale ontwikkeling en welstand van hul toekomstige kinders. 'n Swanger vrou sal haar lewenstyl verander met die oog op die totstandkoming van 'n normale, gesonde baba. Aan die ander kant, is dit so dat sommige swanger vroue optree op maniere wat nie bevorderlik is vir die geboorte van normale, gesonde kinders nie.

Alkoholgebruik gedurende swangerskap gaan gepaard met 'n reeks negatiewe swangerskapuitkomst, insluitende spontane aborsie, problematiese verlossings, fetale groei belemmering en voortydige verlossings. 'n Reeks van siektetoestande en gestremdhede kan, in variërende grade, voorkom in 'n kind wat prenataal aan alkohol blootgestel is. Hierdie reeks van defekte word bestempel as 'n ernstige openbare gesondheidsprobleem waar ook al in die wêreld alkohol vryelik gebruik word.

FAS is die ernstigste diagnoseerbare toestand van 'n spektrum van gebreke wat kollektief fetale alkohol spektrum gebreke genoem word en wat voorkom kan word in kinders wat voorgeboortelik aan alkohol blootgestel is. In die Westerse wêreld is FAS 'n toonaangewende, voorkombare oorsaak van verstandelike gestremdheid in kinders.

Daar is geen kuur vir FAS nie. Geaffekteerde kinders ly aan 'n reeks permanente primêre en sekondêre gestremdhede. Chirurgie kan sekere van die fisiese probleme regstel. Sekere dienste wat beskikbaar is, kan verstandelike en fisiese probleme verbeter sodat hierdie kinders relatief normale lewens kan ly, maar hulle bly

leuenslank onder-gemiddeld in hul fisiese en verstandelike ontwikkeling. FAS en die sosiale en ekonomiese koste daaraan verbonde kan volledig voorkom word as ‘n swanger vrou bloot geen alkohol tydens haar swangerskap gebruik nie.

In hierdie proefskrif word daar eerstens vasgestel óf, en dien wel, wátter, morele verpligtinge swanger vroue (d.i. toekomstige moeders) wat kies om hul swangerskappe te kontinueer, teenoor hul toekomstige kinders het. Ek argumenteer dat vroue kies om ‘n swangerskap voort te sit wanneer hulle die opsie het (soos in SA) om hul swangerskappe te termineer. Wanneer hulle dus kies om nie te termineer nie, is hulle toekomstige moeders, in onderskeiding van swanger vroue wat kies om hul swangerskappe te beëindig. My argument is dat prospektiewe moeders – selfs diesulkes wat alkoholiste is – het *prima facie* morele verpligtinge om hul toekomstige kinders te bevoordeel en nie skade aan te doen nie. Sodanige vroue kan bepaald verantwoordelik gehou word vir hul dade.

Nadat ek ‘n voornemende moeder se morele verantwoordelikkheid om nie te drink tydens swangerskap nie (dus ook haar verantwoordelikheid om FAS te voorkom) oorweeg het, ondersoek ek die samelewing se belang by hierdie kwessies. My argument is dat selfs al het swanger vroue ‘n primêre verantwoordelikheid vir FAS-voorkoming, is hulle nie alleen daarvoor verantwoordelik nie. Ek ontwikkel redes waarom strafeisende maatreëls teen sodanige vroue onwenslik is, en ek stel voor wat ek meen ‘n eties vanpaste sosiale respons is om FAS te voorkom.

Ten slotte oorweeg ek of kinders met FAS onder Suid-Afrikaanse wetgewing toegelaat behoort te word om regsgedinge teen hul moeders aanhangig te maak ten einde vergoeding te ontvang. My argument is dat al kan kinders teoreties sulke eise teen hul moeders instel, dit waarskynlik oneffektief sal wees met die oog op die voorkoming van FAS.

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Chapter 1 – Introduction

1. Introduction

Developments in science and technology, such as contraception, abortion and prenatal screening, “have produced unprecedented conditions under which individuals can control reproduction” (Ankeny 2007:38). Nowadays pregnancy is largely treated as a medical process. Mullins (2005:54) explains that this medicalization of “pregnancy involves interpreting pregnancy as a disruption to health that necessarily requires expert medical intervention, and thinking of pregnancy as primarily about health and illness. Pregnancy is treated as a medical event requiring risk management monitoring” (cited in Kukla 2005) and education, both inside and outside of the health care setting (Kukla 2005). This is not necessarily a bad thing because medicalization has brought with it benefits including the technological means to monitor fetal development and acquire knowledge of maternal and fetal risks. At the same time, pregnant women are advised and generally “expected to survey and discipline virtually all aspects of their bodies and lives” (Kukla 2005), including what they consume and what activities to engage in for the sake of ensuring the birth of a normal healthy child.

From the perspective of behaviour, most pregnant women who plan to continue a pregnancy, act in ways that are conducive to the normal development and welfare of their fetuses. With the intent to deliver a normal healthy baby, a pregnant woman will alter her lifestyle accordingly by, for example, abstaining from certain behaviours and substances, or, adopting others, and generally following medical advice. On the other

hand some pregnant women behave in ways that are not conducive to the birth of normal healthy children.

1.1. The Effects and Impact of Drinking During Pregnancy

Although people have, for centuries, hypothesized about alcohol's potentially damaging effects on the fetus and on pregnancy outcomes (Abel 1999), it was not until the turn of the 20th century that a specific medical link between prenatal alcohol exposure and fetal outcomes was identified (Abel 1990; Armstrong 1998; Streissguth, et al. 1980). Drinking during pregnancy has been correlated with an increase in spontaneous abortion, fetal growth retardation, premature delivery, abruption placentae and breech presentations (DeVille & Kopelman 1998).

A child who was exposed to alcohol prenatally can suffer a variety of disorders and disabilities, in varying degrees. Fetal alcohol spectrum disorder (FASD) is a collective term encompassing the various clinical diagnoses that can occur in a child (CDC 2005). Fetal alcohol syndrome (FAS) is the most extreme condition that can occur in a child whose mother drinks during pregnancy (CDC 2005; Hoyme, et al. 2005; IOM 1996). In the Western world FAS is a “leading preventable cause of mental retardation” (Abel & Sokol 1986; Maier & West 2001).

Less severe conditions on the spectrum of disorders are Alcohol-Related Neurological Defects (ARND) and Alcohol-Related Birth Defects (ARBD). FAS is a leading preventable cause of mental disability (Abel & Sokol 1986; Floyd, et al. 2009), and “is a major public health issue in both well and poorly resourced countries where alcohol is widely used” (Rendall-Mkosi, et al. 2008).

A child with FAS suffers a range of permanent physical and cognitive disabilities (Chudley, et al. 2005; Hoyme, et al. 2005; Mattson, et al. 1997; May, et al. 2009;

Sampson, et al. 1997; Stratton, Howe & Battaglia 1996; Streissguth, et al. 2004). The child displays central nervous system (CNS) damage; has distinct dysmorphic facial features and is significantly below average height and weight or both (Chudley, et al. 2005; Hoyme, et al. 2005; Mattson, et al. 1997; Streissguth, et. 1994), and has a reduced normal chance of leading an independent life. Disabilities in lifestyle and daily function are both frequent and debilitating for FASD children, their families and society at large (Spohr, et al. 2007; Streissguth, et al. 2004). Additionally, the child's condition may be further impaired by the social circumstances in which he or she is raised (Streissguth, et al. 1994).

The occurrence of FAS has not been determined in all of South Africa's nine provinces and no single national study has been conducted to determine its prevalence (Urban, et al. 2015). However, several localised studies found the prevalence of FAS to be particularly high (May, et al. 2000; 2007; Urban, et al. 2015; Viljoen, et al. 2003; 2005). "Internationally the most widely used summary prevalence estimate of FAS is 1 to 1.5 cases per 1000 live births" (Pyettfor, et al. 2007). Data from the United States indicates "that 1% of newborns fall into the spectrum of fetal alcohol disorders" (Rendall-Mkosi, et al. 2008). In some communities in South Africa the rates have been "estimated to be 18 to 141 times greater than those for the various populations in the United States" (Parry & Pluddemann 1998). Surveys involving Grade 1 school children in the Northern Cape, Western Cape and Gauteng provinces in South Africa found the "prevalence of FAS to be more than 40 cases per 1000 children in the Western and Northern Cape and more than 20 cases per 1000 children in Gauteng" (Rosenthal, Christianson & Cordero 2005). When these figures are read alongside the reported rates of drinking during pregnancy and drinking among sexually active women of reproductive age who may not be using effective

contraception, it paints a picture of a potentially huge public health problem for the country.

The exact fiscal impact of FAS does not appear to have been calculated in South Africa. Where the issue is discussed, it seems to be under the general cost of alcohol abuse and birth defects to society. “A conservative estimate of the economic costs of alcohol abuse based on research studies conducted in other countries is 1% of gross domestic product (GDP)” (Freeman & Parry 2006). Between 2000 and 2001, the harmful use of alcohol reportedly cost the South African economy approximately nine billion rand a year (Parry, Myers & Tiede 2003). More recent cost calculations estimate “the combined total tangible and intangible costs of alcohol harm to the economy” (Matzopoulos, et al 2014) to be “10 - 12% of the 2009 gross domestic product (GDP). The tangible financial cost of harmful alcohol use alone was estimated at R37.9 billion, or 1.6% of the 2009 GDP” (Matzopoulos, et al 2014). Together with genetic disorders and other birth defects, FAS is estimated to cost the state several billions of rand annually (Department of Health 2001). In 1998, FAS was estimated to cost the US government approximately four billion dollars (Howard, et al. 1998).

There are a few reasons for thinking that FAS cost estimates for South Africa would yield higher results to that of the US. This is largely related to the difference in health care system structures and public policy approaches. Other reasons relate to general challenges in screening for maternal alcohol use and diagnosing the range of conditions that fall on the FASD continuum (British Medical Association 2007). It is for example possible that women under-report their drinking behaviour for various reasons that have to do with the sensitive nature of questions about alcohol use and fear of being stigmatised (Gfroerer, Wright & Kopstein 1997; Mphi 1994; Stockwell,

et al. 2004). Moreover because there are different diagnostic systems to screen for FASD, medical professionals and facilities may vary in their diagnosis (Aase, Jones & Clarren 1995; Astley 2011; Astley 2006). In South Africa where there is a shortage of medical professionals and consequently ones who can use validated screening and diagnostic tools (Burd 2006), and where other conditions such as HIV/AIDS are prioritised, it is possible that many children are not diagnosed or may be misdiagnosed.

There is no cure for FAS. Alcohol's potentially damaging effects on a fetus and consequently the born child are permanent and cause problems that persist throughout an affected individual's life. Surgery can repair some of the physical problems and services can be made available to improve mental and physical development so that children may lead relatively normal lives, but they remain below average in physical and mental development throughout their lives (Streissguth, et al. 1994; 2004).

2. Rationale/Background

2.1. Respect for Autonomy

Western philosophical traditions and liberal societies place high value on the preservation of autonomy and recognise a general duty to respect it and even to promote its exercise. There is a general "presumption that individuals should be free to do what they wish unless we can justify a limitation" on their autonomy (Wertheimer 2002:38-59). Compelling reasons are required to justify restricting the power of individuals to make their own choices and direct their own lives.

The moral philosophies of both Kant (1996 [1797]) and Mill (1859) endorse and recognise the value of autonomy, even though neither used the term "autonomy" and value autonomy for different reasons. A Kantian account of autonomy is tied to

Immanuel Kant's notion of respect for persons and sees autonomy as having intrinsic moral value. For Kant respect is based on recognising those special qualities that distinguish persons from other beings. Persons are thought to have the capacity for rationality and the ability to make moral choices. These qualities entail that persons have dignity, which in turn, entitles them to respect. According to Kant we respect persons when we treat others, "never merely as a means to an end, but always at the same time as an end" (Kant 1996 [1797]). Kant calls this maxim the categorical imperative: a supreme principle underlying all morality. He expresses this maxim in a number of ways: the above is called the "Formula of Humanity". Expressed as the "Formula of the Universal Law", the maxim instructs us to "act only in accordance with that maxim through which you can at the same time will that it become a universal law" (Kant 1996, G 421/39). The underlying idea is that one cannot claim a moral right to act in a certain way with a particular purpose, unless one would want to grant everyone else the right to do the same. Our moral duties must be applicable to everyone: one cannot claim special rights to behave in certain ways for oneself alone. Kant suggests that the different expressions of this formula lead to the same conclusions regarding what our moral duties are. He says that we can use this formula to test what our moral duties are.

Like Kant, Mill also does not specifically talk of autonomy. Rather he uses concepts such as "liberty", "individuality" and "originality", which can roughly be construed as the freedom to create and live according to one's own life plan. Mill endorses autonomy because of its instrumental value. For him, a society that fosters respect for individual autonomy will be more progressive and happier. Mill's account of respect for autonomy can be derived from his seminal essay, *On Liberty*, wherein he argues against paternalism and proposes the famous "harm principle" as a justification for

restricting a person's freedom of choice and action. Mill offers two maxims that set the limits of interference in individual action. "These maxims are, first, that the individual is not accountable to society for his actions, in so far as these concern the interests of no person but himself. Advice, instruction, persuasion, and avoidance by other people if thought necessary by them for their own good, are the only measures by which society can justifiably express its dislike or disapprobation of his conduct. Secondly, that for such actions as are prejudicial to the interests of others, the individual is accountable, and may be subjected either to social or to legal punishment, if society is of the opinion that the one or the other is requisite for its protection" (Mill 1859, Ch. 5). "Claims to autonomy" or a right to do as one pleases therefore has "greatest weight" when one's "decisions primarily affect" only oneself and will "not harm others" (Ankeny 2007).

Mill recognises that a "person may cause evil to others not only by his actions but by his inaction" (Mill 1859, Ch. 1), and that "in either case he is justly accountable to them for the injury" (Mill 1859, Ch. 1). However he cautions that the latter case "requires a much more cautious exercise of compulsion than the former" (Mill 1859, Ch. 1). According to him to "make anyone answerable for not preventing evil, is comparatively speaking, the exception" (Mill 1859, Ch. 1).

Mill is a renowned utilitarian so consequences matter morally, yet he recognises that duties of non-interference (so-called negative rights) may be stronger than duties grounded in the principle of beneficence (so-called positive rights). He suggests that causing harm is always wrong; a *prima facie* case "for punishing him, by law, or, where legal penalties are not safely applicable, by general disapprobation" (Mill 1859, Ch. 1), but that punishing someone may not always be the best approach. Mill therefore recognises that there may sometimes be overriding reasons for not holding

an individual to the responsibility; but says that “these reasons must arise from the special expediencies of the case: either because it is a kind of case in which he is on the whole likely to act better, when left to his own discretion, than when controlled in any way in which society has it in their power to control him; or because the attempt to exercise control would produce other evils, greater than those which it would prevent. When such reasons as these preclude the enforcement of responsibility, the conscience of the agent himself should step into the vacant judgment seat, and protect those interests of others which have no external protection” (Mill 1859, Ch. 1).

Mill therefore recognises that regulation might sometimes be more harmful than the behaviour in question or that the harmful behaviour is very costly or has other negative effects. Where this is the case, it seems Mill permits society to impose social sanctions i.e. punish the harmful act or omission in question by means of for example stigmatisation, or as he states “by the reproaches of his own conscience” (Mill 1859, Ch. 1).

Mill appears to also tolerate restrictions on individual freedom that aim to provide benefits to others. He allows the state to compel members of society to aid others / provide benefits to others. He argues that “every one who receives the protection of society owes a return for the benefit, and the fact of living in society renders it indispensable that each should be bound to observe a certain line of conduct towards the rest. This conduct consists first, in not injuring the interests of one another; or rather certain interests, which, either by express legal provision or by tacit understanding, ought to be considered as rights; and secondly, in each person's bearing his share (to be fixed on some equitable principle) of the labours and sacrifices incurred for defending the society or its members from injury and molestation” (Mill 1859, Ch. 4). Therefore, “In all things which regard the external

relations of the individual, he is *de jure* amenable to those whose interests are concerned, and if need be, to society as their protector” (Mill 1859, Ch. 1).

2.2. Reproductive Autonomy and the Right to Reproduce

Individual autonomy is “central to debates about decision-making with regard to reproduction” (Ankeny 2007:38). Reproductive “autonomy is among many important forms of autonomy” that liberal states strive to uphold. “Decisions about reproduction also relate closely to our identities as human beings, our well-being, and our deepest relationships with others” (Ankeny 2007:39). Usually our decisions about whether and with whom to reproduce “reflect our most closely held values about how we wish to live our lives, and what makes something a good life” (Ankeny 2007:39).

However, reproductive autonomy, which may be understood as the right or freedom to reproduce, also has “its moral basis in equality, particularly equality of opportunity between the sexes” (Ankeny 2007:39). One of the implications of the right to make choices about reproduction is that it allows individuals the “freedom of choice about when to take on the various burdens and responsibilities associated with pregnancy”, birth and parenting, “which is especially important for women, who often assume most of” the “responsibilities” and “whose bodies are significantly affected by decisions about reproductive decisions” (Ankeny 2007:39). Individuals who do not desire to reproduce, hence become parents, can attain this goal by avoiding conception altogether, whether through sexual abstinence, contraception or abortion (Ankeny 2007).

2.2.1. Views on the Right to Reproduce

Although there is widespread recognition that the “ability to control what happens to one’s body is vital to the exercise of autonomy”, there are “a range of views regarding the” nature and “extent of the right to reproduce” (Ankeny 2007:39). These can roughly be divided into conservative and liberal views.

Conservative views hold that reproduction is a natural process that “should not be interfered with”; neither “should technology be used to intervene in or achieve reproduction” (Ankeny 2007:40). They also reject the idea “that rights should serve as a point for understanding moral arguments about reproduction. Instead they suggest that there may be moral arguments to support the freedom to have children, such as” those based on the “desire to have a child that” outweighs “any arguments that people should not be allowed to do so” (Ankeny 2007:41). Moreover, they point out “that rights talk fails to capture what is essential about reproductive choices and relationships in families” (Ankeny 2007:41), and reduce personal and intimate relationships with others to being contractual in nature; where one person has a right and the other concomitant duties to be fulfilled.

Advocates of the liberal view strongly value autonomy and equality. “Liberal views focus on the harm principle, which holds that we can act as we wish so long as we do not harm others” (Ankeny 2007:40). Restrictions on the right to reproduce are therefore justified if others will be harmed by the decision. In general, people should therefore be free to choose whether and when they want to reproduce and no one should interfere with their decision. Some liberal views however insist that the right to reproduce is broader than mere non-interference in an individual’s right to reproduce. For them the right to reproduce is not only a negative right of non-interference but also entails a positive right to assist individuals in realising their desire to reproduce

or become parents by for example funding assisted reproduction for infertile adults (Ankeny 2007).

Although it is a widely held view that people have a right to reproduce, the scope of the right is controversial and the issues at stake cannot readily be resolved to individual rights principles. To view the problems that maternal drinking during pregnancy and consequently FAS give rise to from a simple rights-based approach is unhelpful because it cannot adequately resolve the ethical problems it raises. Because rights-based approaches can recognise the notion of fetal rights, rights-based approaches typically view the problem as a conflict between a woman's rights and that of her fetus – a situation often described as maternal-fetal conflict.

Maternal-fetal conflicts pose two fundamental and difficult moral questions. The first question - is the fetus a “person”, i.e. an entity that has rights? - relates to the moral status of the fetus. The second question - does a fetus's purported right not to be harmed outweigh a pregnant woman's rights? - concern the resolution of conflicting rights and claims. Although all of the parties to the maternal-fetal debate seem to agree that it is usually morally wrong to harm an innocent or non-consenting person, there is considerable disagreement over the ontological and moral status of the fetus. If the fetus is a person, then it has rights that cannot easily be overridden. The implication is that a pregnant woman will have to balance the rights of her fetus with those of her own. Moreover, if a fetus has rights, then the state has an interest not only in protecting a woman's interest in being free from certain forms of state control but it would also have an interest in preventing harm to fetuses. However, if it is not the sort of entity that has rights, then it is not seriously wrong to harm it, and interference in a woman's right may not be justified.

A particular problem with rights-based approaches is that rights principles must “be refined, weighed against one another and applied within a complex framework of moral values, legal considerations, practical issues and attention to consequences” (Mathieu 1995:2). Therefore the espousal of one of these rights, i.e. those of the child or those of the woman, leads to very different conclusion regarding women’s responsibility and the legitimacy of state interference and kinds of interventions that may be justifiable. For example, one rights-based view is that the state’s recognition of an individual’s right to autonomy, and more specifically a “woman’s right to decide what happens to her own body is inconsistent” (Mathieu 1995:2) with one that involves coercion or one that seeks to give priority to protecting a child from avoidable harm. A different rights-based view is that the state is justified in overriding or restricting a woman’s autonomy for the sake of her prospective child. Trying to resolve the problem from an exclusively rights-based approach is therefore inadequate, largely because resolution of the problems relies on how well one argues for the rights of either party. If one supports the claim that a competent adult pregnant woman’s rights should override fetal rights (assuming that fetuses have rights) then she is doing no more than prioritising her rights over those of her fetus. Equally, if one argues from the position of fetal rights, then the woman would have to balance her rights with those of her fetus.

A graver concern about rights-based approaches to the problem of maternal drinking during pregnancy is that, by pitting the rights of the woman against those of her fetus, a perception is created that a woman and her fetus are in fact two separate entities. Considering how we ought ethically to treat the human fetus from a rights-based perspective presents the relationship between a pregnant woman and her fetus as one in which the fetus is separable and independent from the woman, and one in which

their interests stand in opposition, when in fact this is not always the case. In this way, rights talk and focus on the moral status of the fetus, offer an impoverished picture of the human condition, because it masks the subtleties and complexities of our relationships and motivations and their role in our lives. Schoeman (1980:9) explains that the “danger of talk about rights of children is that it may encourage people to think that the proper relationship between themselves and their children is the abstract one that the language of rights is forged to suit.... Emphasis on the rights of children might foster thinking about the relationship between parent and child as quasi-contractual, limited, and directed toward the promotion of an abstract public good. Such emphasis unambiguously suggests that the relationship is a one-way relationship aimed almost solely at promoting the best interests of the child”. Characterising the maternal-fetal relationship as a conflict presents the relationship as one in which they are adversaries (Draper 1996; Van Bogaert 2006). This may be contrary to common sense morality which typically sees the fetus as part of the woman’s body, and as a developing human life. Many women who choose to continue a pregnancy are concerned about the welfare of their prospective child and do not see the relationship as one where they are adversaries (Minkoff & Paltrow 2004).

“Philosophers continue to debate whether fetuses are the kinds of beings who can have moral rights; whether rights talk in general has any point unless the being to whom rights are ascribed is in a position to” exercise choice, “and whether ascribing some rights to beings commits us to ascribing others (i.e., must have a whole packet of general rights or none at all, or may one ascribe certain rights to one kind of being and other rights to other kinds of beings? Many of these abstract philosophical issues about rights” are usually “argued inconclusively” (Schoeman 1980), because one’s view of how we ought to treat the human fetus will depend largely, if not exclusively,

on one's view of the moral status of the fetus - something which many people disagree on. And even if we were to agree that fetuses have rights, we would still need to decide whose rights carry more weight on the moral calculus: that of the pregnant woman or that of her fetus? Even if the fetus has rights, it does not necessarily follow that a woman's rights are inferior to those of the fetus, in other words that the fetus's claims are stronger than those of the woman in whose body it resides (Thomson 1971). It still needs to be shown that the woman has a duty to do absolutely everything possible to keep the fetus alive or to protect it from harm, particularly if there may be other compelling considerations which outweigh any rights it may have - whether to continued existence or protection from harm.

Because of the shortcomings of viewing the problem of maternal drinking during pregnancy from a rights-based perspective, this dissertation seeks to consider the problem of maternal drinking and consequently FAS from an ethic of moral responsibility. The idea that one can have responsibility even to/for entities that do not have rights resonates with common sense morality. We tend to for example think that people have duties to their pets, even though their pets do not have rights, in the same way that human persons do. We also tend to think that we have duties to future generations of people, even though they may not have been conceived. It is not uncommon to hear people talk about the legacy that they would like to leave for their grandchildren. Therefore for purposes of this dissertation, it does not seem imperative to debate and settle the question of the moral status of the fetus.¹

¹ The idea that we have moral responsibility even toward distant others (strangers and future generations) was first promoted by Hans Jonas in his book, *The Imperative of Responsibility*, published in 1979.

Even if the fetus has no or little moral standing (rights), it does not mean that women have carte blanche to do whatever they please while pregnant. One could plausibly argue that women, who choose to continue a pregnancy to term, thereby accept responsibility for and to their fetuses/prospective children. On this account reproductive autonomy is not devoid of responsibility. The idea that the exercise of one's reproductive autonomy carries concomitant responsibilities is not unusual. Once a woman accepts a pregnancy, we tend to think that she ought to act in ways that will benefit and not harm it. The right to reproduce is therefore not ordinarily understood in absolutist terms, but rather as a *prima facie* claim, power or freedom whose content is determined by its interaction with other rights and responsibilities. It is not obvious that the right to reproduce (always) overrides other considerations such as the rights of others to not be harmed or that it entails the rights to populate the world without thought. Pregnant women, have a right to have their autonomy respected, even to accept serious health risks for themselves, but is not obvious that this right entails a right to impose such risk on her prospective child, or that we should regard behaviour during pregnancy as a matter of exclusively personal choice, i.e. as no more than the exercise of one's reproductive autonomy or one's right to reproduce.

2.3. Moral Responsibility

Andrew Eshleman (2014) explains that "Moral responsibility is both related to and different from causal and legal responsibility". A person is legally responsible for his or her actions when he or she will be penalised in a court system for an event that occurred. Although, it may often be the case that when a person is morally responsible for some act, they are also legally responsible" for it, "there are exceptions to this rule" (Eshleman 2014). While there may be compelling moral reasons to act in a

morally responsible way, there may be compelling reasons to not make it legally obligatory to behave in that way.

Moral responsibility is also linked to yet distinct from causal responsibility. Assigning causal responsibility to something is simply to indicate the factors responsible for producing the event or outcomes or to identify a causal connection between an earlier occurrence and the outcome (Klein 1995). Both human and non-human entities can cause an outcome, but only human persons have moral responsibility.

Moral responsibility concerns an individual's prospective and retrospective responsibilities. Prospective responsibilities are those obligations or duties "that I have before the event, those matters that it is up to me to attend to or take care of" (Klein 1995; Williams 2009). Retrospective responsibility concerns the assignment of blame or praise, for what a person has done or failed to do, in discharging their prospective responsibilities (Duff 1998). It involves evaluating and making judgments about the morality of a person's past actions. Retrospective responsibility is related to prospective responsibility because in order to properly ascribe moral responsibility to someone, we need to know what their duties are. Garrath Williams explains that this "judgment typically pictures the person as liable to various consequences: to feeling remorse (or pride), to being blamed (or praised), to making amends (or receiving gratitude), and so forth" (Williams 2009). Craig explains that "to hold A responsible for an event is, not yet to say that A should be blamed for it, partly because praise, rather than blame, may be due; and partly because I can avoid blame for an untoward event by justifying my action" (Craig 1998:291), as may be the case when we claim to have killed someone in self-defence.

Moral responsibility is also "a virtue that people (and organizations) may exhibit in one area of their conduct or perhaps exemplify in their entire lives" (Williams 2009).

Therefore, moral responsibility also concerns making judgments about a person's attitude to their obligations, where a responsible person is one who "can be relied on to judge and to act in certain morally desirable ways" (Williams 2009) and "can be counted on to take her responsibilities seriously" (Williams 2009). On the other hand, "the irresponsible person is not one who lacks prospective responsibilities, nor is she one who may not be held responsible retrospectively. It is that she does not take her responsibilities seriously" (Williams 2009). Consequently we usually praise people "for acting in morally responsible ways" if they have "caused some good state of affairs to occur" (Schoeman 1980).

Andrew Eshleman (2014) explains that Aristotle thought "that only a certain kind of agent qualifies as a moral agent and is thus properly subject to ascriptions of responsibility", namely, one who possesses a capacity for decision. "For Aristotle, a decision is a particular kind of desire resulting from deliberation, one that expresses the agent's conception of what is good" (Eshleman 2014). Thus "Aristotle's general proposal is that one is an apt candidate for praise or blame if and only if the action and/or disposition is voluntary. According to Aristotle, a voluntary action or trait has two distinctive features. First, there is a control condition: the action or trait must have its origin in the agent. That is, it must be up to the agent whether to perform that action or possess the trait—it cannot be compelled externally. Second, Aristotle proposes an epistemic condition: the agent must be aware of what it is she is doing or bringing about" (Eshleman 2014).

The capacities to make decisions and to act freely are generally held to be necessary conditions to properly ascribe moral responsibility. This means that one can be morally responsible for something only if one's choice was made freely and if it affects another's interests and if one can reasonably have been expected to have

anticipated the likely consequences of one's choice or action. "Normal human adults represent our paradigm case" (Williams 2009) of moral agents, i.e. individuals who can accept and discharge responsibilities and have responsibility. Because we tend to think that competent adults are capable of performing voluntary actions or freely choosing their actions, we believe that they can and should be held responsible for their consequences. However, if one or another of the necessary conditions is not present at the time of the act, they may be excused from moral responsibility.

2.3.1. Moral Obligations to Future People

The idea that we can have moral obligations toward future people has important moral implications. Partridge (2003) correctly points out that when we begin to seriously consider our moral obligations to future people; it soon becomes apparent that it is not as simple a matter as just extending our moral duties towards contemporary, i.e. actual or existing, persons, to include those who will exist in the future. Since future people do not presently exist, how is it that we can have moral duties toward them? Do our moral obligations extend only to our contemporaries or do we also have obligations to future people?

Jen Saugstad (1994) offers a striking illustration to support the claim that we have moral obligations to future people. Saugstad says, "Suppose that country A launches a missile killing the innocent denizens of country B. Their right to life has been infringed. Now suppose again that country A launches the missile, only this time it follows an orbit in space before it kills the innocent denizens of country B *two centuries later*. If in the former case, this must surely also be an infringement of these future victims' right to life. The fact that the missile hits its target two centuries after it was launched is morally irrelevant" (Saugstad 1994). Using the same reasoning we

therefore can reasonably suggest that pregnant women who choose to continue their pregnancies have *prima facie* moral obligations to not harm their fetuses, because it is the resultant children that will suffer the fate of their choices.

According to Joel Feinberg (1984), “Talk of a right not to be born is a compendious way of referring to the plausible moral requirement that no child be brought into the world unless certain very minimal conditions of wellbeing are assured. When a child is brought into existence even though those requirements have not been observed, he has been wronged” (Steinbock & McClamrock 1994). Feinberg suggests that these “minimal conditions of wellbeing amount to a requirement that we not doom the child’s future interests to total defeat. The advance dooming of a child’s most basic interests – those essential to the existence and advancement of any ulterior interests – deprives the child of what might be called his birthrights” (Steinbock & McClamrock 1994). According to Feinberg, “if the conditions to enable” a child “to fulfil his most basic interests are destroyed before he is born and we permit him nevertheless to be born, we become party to the violation of his rights” (Freeman 1997:167). He explains that “before the fetus becomes a person it is a potential person with the potential attributes, including the possession of rights of a person” (Feinberg, 1994:24). He says that “if the potential person has an unalterable destiny of extreme impairment and suffering (Feinberg 1994:24), and “if one of the rights of the child will have at birth (at the presumed onset of personhood) is the right to be free of these total impediments to development and fulfilment, then the potential rights at the very moment they are actualized are violated” (Feinberg 1994:24). A severely disabled child comes “into existence not simply with rights but with already violated” (Feinberg 1994:24) rights. For Feinberg the child “has a grievance, a claim that he has been wronged” (Feinberg 1994:24). Thus, if a child cannot have that to which he has a

birthright, he is harmed if he is brought to birth (Feinberg, 1985: 71-72). Applying his analysis of harm to the “case of prenatal harms, Feinberg concludes that harm can be caused to a person before his birth in virtue of the later interests of the child that can already be anticipated” (Steinbock & McClamrock 1994). Thus, “on the assumption that the fetus will be born, we can ascribe to it certain interests, which can be set back, thwarted or defeated by actions done before the potential person becomes an actual person” (Steinbock & McClamrock 1994).

2.3.2. Parental Responsibility

“As persons, children ought to be thought of as possessing rights, but as infants relationship to their parents, they are to be thought of primarily as having needs” (Schoeman 1980); the satisfaction of which implies a close relationship with primarily, but not necessarily exclusive, their mothers. Thus while the language of rights makes sense in the case of setting moral boundaries for the relationship between older children and their parents, it seems inappropriate to focus primarily on rights when those children are very young or still fetuses. The language of rights may enhance our appreciation of the moral boundaries which separate people, by stressing the moral independence and autonomy of others, however, in common morality we tend to think that parents have responsibilities (parental responsibility) to their children, for various reasons, other than because children have rights, including: because of the special relationship thought to exist between parent and child (Manning 2001; Schoeman 1980); because of the genetic tie that exists between the parent and child (Hall 1999); or because they are (partly) responsible for causing them to come into existence (Blustein 1997; Nelson 1991); or because of the child’s special

needs and vulnerabilities (Goodin 1985; Held 2006) or because of the child's unequal status in the relationship (Jonas 1979).

Common sense morality understands "us as having special obligations to those to whom we stand in some special relationship" (Jeske 2008). Special obligations are those duties that are not necessarily owed to everyone, but only to a subset of people with whom we stand in special relationships (Ross 1930). By contrast natural duties are "moral requirements which apply to all men [and women] irrespective of status or acts performed" (Jeske 2008) and "owed by all persons to others" (Jeske 2008). Natural duties are therefore those duties "that are owed to all persons qua persons" (Jeske 2008), whereas one's relationship with another "is fundamental to any explanation of special obligations" (Jeske 2008) to that person. The basic or fundamental justification for having special obligations is therefore not because of the intrinsic nature of persons, but rather because of the special relationships that exist among people.

Generally when we "admonish parents for failing in their relationship to their young children it is because we find them not furnishing the goods such as love, attention and security" (Schoeman 1980) we think parents ought to provide, rather than because they fail to respect the child's rights. We tend to "find them short on caring and intimacy and insensitive to the state of dependency and vulnerability into which children are born" (Schoeman 1980:8). Rather than think that a child has a right to be cared for by its parents, we tend to think that parents have this responsibility, independent of any idea of a right. While parents may expect some reciprocity from their children when they are old, for love and effort spent on them, "this is certainly not the motive for doing so, and is still less a condition of the responsibility itself one owes toward the child" (Jonas 1979:39).

The recognition that parents have obligations toward their children can be traced back to John Stuart Mill, who argued “that to bring a child into existence without a fair prospect of being able, not only to provide food for its body, but instruction and training for its mind is a moral crime, both against the unfortunate offspring and against society” (Mill 1859, Ch. 5) for which parents may be held liable. This can be seen as constituting a limitation on individual autonomy and an application of his famous “harm principle”. Other notable thinkers including Feinberg (1986), Murray (1991; 1987), Purdy (1999), Steinbock (1986) and Benatar (2006), have continued on this train of thought.

The idea of parental responsibility is a relatively uncontroversial necessity. However, its scope is contested. What exactly does such responsibility entail and on what basis should/can we judge whether (or not) parents fulfil their responsibilities are questions that remain subject to dispute and unresolved, yet relevant and important in contemporary times. One reason why the scope of parental responsibility is controversial relates to the idea that there is a morally relevant difference between positive and negative duties. Negative duties are injunctions in that they set out what we may not do to others without violating their rights. They therefore impose on us duties to refrain from interfering or harming other persons e.g. the duty to not kill an innocent person. Negative duties are thought to be universal, fundamental and presumptively overriding and “based on the value of justice and respect for human dignity, autonomy, freedom, and rights” (Smith 2005:481).

On the other hand, positive duties are based on the value of charity or benevolence (as opposed to justice) (Smith 2005:481). Positive duties require positive action, or positive duties to help others, unlike negative duties which require us to merely refrain from harming others or interfering in their rights. Moreover, unlike negative duties, positive

duties do not apply universally, but only generally. Positive duties correspond to positive rights only in cases of special obligations due to special relationships.

Some commentators “agree that there is a moral defect in parents who intend to conceive a child but are indifferent to whether” the “child will be born” with a “potential for” a normal existence (Savulescu 2009). Benatar (2006: 2492) for example suggests that procreation that stands a high chance of serious harm should be actively discouraged and sometimes even prevented. Savulescu and Kahane (2008) go as far as to argue, that “[I]f prospective parents have moral reasons to care about the potential well-being of their future children, then it would seem that they should also have reason to aim to have children who are more advantaged rather than leave this to chance or nature” (Savulescu & Kahane 2008). Essentially what these authors argue is that parents also have beneficence-based obligations to their children that entail a duty to choose to produce the best possible children, where this is possible.

2.3.3. Are There Duties to [Not] Reproduce?

Although we can generally agree that individuals may and should be free to reproduce (or not), less clear is whether they may sometimes have duties to avoid reproduction. Does the right to reproduce mean that people should always reproduce or that they have an unrestricted right to do so? Are there instances where we may think that reproduction is wrong and immoral and that individuals should avoid conception and birth, hence parenting? Does making responsible decisions about reproduction mean that women should sometimes terminate a pregnancy? The idea that parents harm their children and society if they are unable to provide their children with a decent quality of life can be traced back to the works of John Stuart Mill (1859).

“Although future children” may “not have” full or any “moral standing” (Ankeny 2007), the principle of parental responsibility instructs prospective parents to take into account the interests of their future children when making decisions about reproduction (Steinbock & McClamrock 1994). Decisions to reproduce are therefore “accompanied by strong, positive duties to promote” the “health” and welfare “to any future child” (Ankeny 2007). Certain decisions “arise from the very decision” (Ankeny 2007) to reproduce, including rearing the “resulting child and to provide a life that is normal, at least in terms of societal norms” (Ankeny 2007). This means “that prospective parents who are in a position to prevent harm coming to a child have duties to mitigate or prevent such harms and suffering” (Ankeny 2007).

The issue “of whether we owe certain” duties “to our” children, “particularly so that they do not inherit genetic disease conditions has been extensively debated in the Bioethics literature” (Ankeny 2007). Commentators such as Purdy (1989) have for instance argued that people should refrain from having children “where there is a family history for genetic disease”, whereas others such as Arras (1990) and Harris (1989) have equally argued that people should refrain from reproduction where their children will suffer serious disability, “by practising abstinence, using contraception and prenatal testing and terminating a pregnancy (where these are socially acceptable options). Julian Savulescu for instance defends a principle of procreative beneficence, which he argues posits an obligation on individuals to “select the child, of the possible children they could have, who is expected to have the best life, or at least as good a life as the others, based on the relevant, available information” (Savulescu 2001).

Essentially Savulescu proposes that given the range of factors e.g. intelligence and disability, affect a child’s chances at leading a good life that individuals should (have a duty) to use available to “genetic information and technologies to guide” their

“reproductive decision-making” (Ankeny 2007). This is controversial because Savulescu’s “argument makes an indirect claim about the duty not to have certain types of children, where other options are available” (Ankeny 2007).

Although it may be argued that his argument undermines widely held “views of human life as a gift to be unconditionally accepted”, it must be kept in mind that parents have, “in many senses, always had considerable but not unlimited authority, to shape their children’s lives through choices about education, , upbringing and so on” (Ankeny 2007). Prenatal genetic testing may then be just another means for prospective parents to shape their children’s lives.

The “argument for a duty to prevent passing on serious genetic diseases” to one’s biological offspring “typically begins from the idea that we should try to provide every child with a normal opportunity for health” (Ankeny 2007). On this understanding, “every child has an open future, which means that he or she has a right not to be raised in a manner that closes off a reasonable range of opportunities particularly for future autonomous choices” (Ankeny 2007). An “extreme position holds that termination of pregnancy is” obligatory (as opposed to merely voluntary); “when a woman learns she is pregnant with a fetus which has a serious problem and will develop into a child who will experience considerable pain and suffering” (Ankeny 2007). The argument rests “on the idea that it is wrong to deliberately inflict” harm, “and that a life of suffering is a harm to the child and thus not in its best interests” (Ankeny 2007). Although the woman who terminates a pregnancy may suffer psychological harm as a consequence, these harms are arguably “less weighty than the potential” harms “to the child who would experience severe impairment and suffering” (Ankeny 2007).

“Others” however “argue that there is no moral duty” to terminate a pregnancy “even in cases of genetic or other disease conditions, particularly where potential parents view the fetus as a child” (Ankeny 2007). They argue that “prospective parents are not required to find out about their genetic constitution when planning to reproduce and that ignoring genetic information can be reconciled with some views of responsible” or “good” parenting, particularly “those that take parenthood to be essentially an unconditional project in which parents” should “commit themselves to nurturing any kind of child” (Ankeny 2007). Others point out that, even though prenatal and “other forms of genetic testing may be useful when making decisions about reproduction, it does not prevent harm to actual, future children” (Ankeny 2007). Parents may still opt to continue a pregnancy despite the risks. Finally some others argue that children with disabling conditions are “not harmed by being born because the only other option for that child was not to have been born, and thus never to have existed” (Ankeny 2007). By these accounts “a pregnant woman has a right to remain in ignorance of any genetic conditions present in the fetus she is carrying” (Ankeny 2007) because the constitution of one’s child doesn’t/shouldn’t matter. Children are not harmed by being born or by their not being born. Mary-Anne Warren (1978) expresses the point in the following manner: “failing to have a child, even when you could have a happy one, is neither right nor wrong... But the same cannot be said of *having* a child, since in this case the action results in the existence of a new person whose interests must be taken into account. Having a child under conditions which should enable one to predict that it will be very unhappy is morally objectionable, not because it violates the rights of a presently existing potential person, but because it results in the frustration of the interests of an actual person in the future” (cited in Steinbock & McClamrock 1994).

Underlying all of these arguments is the core idea “about a relatively objective notion of acceptable quality of life, upon which” many “or all could agree, and which individuals” can “use to assess their duties and responsibilities. However, individuals’ experiences of various conditions and life experiences differ dramatically” (Ankeny 2007). Thus it could “be argued that individual family experiences and understandings should determine individuals’ senses of” their “duties” and responsibilities “regarding” reproduction (Ankeny 2007). “If a family is willing to raise a child with” serious mental retardation “there is no strong moral” duty to claim that they have a duty to avoid reproduction (Ankeny 2007). “Part of having a normal range of life opportunities includes” (not) “having and raising children” and “it is an important” determinant “of the good life for many people (Ankeny 2007). Some would argue that no one would want a loved one to suffer” a serious condition or illness (Ankeny 2007).

Given the “diverse opinions and beliefs about the moral legitimacy of termination under various sorts of circumstances”, it seems “difficult to maintain there are objective duties to (or not to) reproduce” (Ankeny 2007). To “claim that children have a right to be born” is problematic because “it is impossible to say what such a right involves” (Ankeny 2007). For example, does it mean that individuals ought to always reproduce and that it would be wrong to use contraception or terminate a pregnancy? “Even if we might be able to outline the basis for such a rights claim, enforcing it” would infringe on the pregnant woman’s “most basic rights and also is likely to undermine the maternal-fetal relationship” (Hornstra 1998).

“Although one assumes a range of responsibilities in making a decision to reproduce, including consideration of the conditions that should be in place to bear and rear a child, there are no obvious objective norms for ideal childrearing conditions. Whether

a child is likely to have a happy and healthy upbringing cannot be gauged directly by e.g. the sexuality, age or marital status of parents” (Ankeny 2007). Although it can be said that responsible reproduction requires careful consideration about the timing and circumstances for reproduction, “there is no strong duty to refrain from” it “except perhaps under extreme conditions where a potential child is likely to experience considerable suffering” (Ankeny 2007).

For many people, “reproduction is an important part of having a good life and deserves protection as a right because it is the usual way to establish a family” (Ankeny 2007). It is for at least this reason that the decision to reproduce or not should remain a decision to be made by individuals. Although one may argue that individuals have duties to take into account their social circumstances and the future lives of their potential children, it is difficult to argue that individuals’ reproductive autonomy should be utterly trumped by other issues and concerns, in other words, that they have strong duties not to reproduce.

3. Problem Statement

A pregnant woman’s behaviour significantly impacts the normal development and health of her fetus (Aronson & Olegard 1987; Cole, et al. 1984; Little, et al. 1982). FAS is not a natural phenomenon. It does not occur as part of the “natural order” of events. Neither is it a hereditary or communicable condition. It cannot be inherited or transmitted between people. Women who drink alcohol during pregnancy and sexually active women of reproductive age who drink and may not be using effective contraception are at risk for having a child with FAS.

Although there is no clear guidance on the amount of alcohol exposure that is harmful to the fetus/child (Barr & Streissguth 2001; Katwan, Adnams & London 2011; Laufer,

et al. 2013), no amount of alcohol can be guaranteed to be safe (Hackler 2011; IOM 1996; Laufer, et al. 2013). The spectrum of disorders that can occur in a child exposed to alcohol prenatally suggests that, because children are not affected in the same way, there must be other factors, beyond drinking during pregnancy, influencing the nature and extent of harm suffered by the child. However, despite the range of determinants and factors that influence a woman's drinking and consequently risk for having a child with FAS, prenatal alcohol exposure is a necessary condition for its occurrence. If a woman does not drink during pregnancy her child is not at risk of a fetal alcohol spectrum disorder.

Alcohol's damaging effects are entirely preventable. The most obvious and effective way to prevent FAS is for women to abstain from alcohol if they are or plan to or might become pregnant. Where socially acceptable, women who do not want to reproduce can avoid pregnancy by using effective contraception, and where abortion is legally permissible. Those who may become pregnant can avoid birth and parenting by terminating their pregnancies.

The knowledge that a woman's behaviour during pregnancy can adversely affect the outcome of her pregnancy seriously challenges the traditional view of pregnancy as a personal matter. It also challenges society's commitment to freedom of choice in general, and raises fundamental ethical, legal and social policy questions that centre on the proper role and function of the state.

Although we may agree that pregnant women have moral obligations to the fetuses that they choose to carry to term, what precisely these obligations may be is not obvious. Do they have a moral obligation to not harm future people? What does to *harm* mean? When is harming or causing harm wrong? Do we harm future people when we make it impossible for them to exist e.g. by using contraception? Do we

harm and thereby wrong them if we do not bring about their existence e.g. by terminating a pregnancy? Do future people have a right to be born? We may agree that people have the right to reproduce, but may they sometimes have a duty to not reproduce? Is it wrong to bring into the world a child that will suffer serious physical or mental disability? Do we have the same kinds of obligations toward future children that we have toward presently living people? If so, how do we balance our obligations toward future people with obligations toward ourselves or those presently existing? Often the interests of these two groups come into conflict. The moral problem, then, is to find the best way to meet both our own interests and those of future people.

4. Goals and Research Questions

This dissertation has five goals. In each case, the relevant concomitant research questions following from each goal is added. The *first* goal of this dissertation is to establish what, generally, if any, are the (possible) moral implications of both becoming pregnant and deciding to carry the fetus to term. Do pregnant women, who choose to carry a pregnancy to term, i.e. prospective mothers, have moral responsibility for and toward their fetuses and consequently prospective children? Or does the pregnant woman's alleged sovereignty over her own body imply a right to harm herself, even to the extent that it amounts to undeniable permanent harm to her fetus and consequently child? Are there limits to women's rights in the context of pregnancies that are carried to term? And if so, what limitations might there be on a prospective mother's autonomy and how are they morally justified? Questions raised by this goal pertain to how the possibility (indeed, as will be argued, the fact) of such responsibilities is reconcilable with the pregnant woman's entitlement to have her autonomy, and her concomitant sovereignty over her own body, be respected.

The *second* goal of this dissertation is to establish exactly what these moral responsibilities are. It is a well-established rule in liberal and just societies that competent individuals enjoy the right to behave as they choose provided that the behaviour is within legal and moral limits. One's right or freedom to do as one pleases is therefore not absolute. Moreover that, with the exercise of one's rights is the co-relative idea of responsibility. What set of moral responsibilities therefore face a woman who opts to carry a pregnancy to term? Does it mean that she has a duty to stop drinking if she is pregnant? Does it mean that she has a duty to avoid reproduction by using contraception or terminating her pregnancy if she is at risk for having a child with FAS? To what extent can she be held morally responsible for prenatal harm incurred by her child? While the prevention of FAS may be a relatively simple matter, questions remain about the extent to which women could be held responsible for all kinds of harms that may be related to their behaviour while pregnant. If harms could be prevented by abstaining from alcohol, what about all kinds of (for the woman beneficial, though not for the fetus) drugs, treatments, activities (including sexual behaviour), and the like? And does society have a role to play in preventing FAS?

The *third* goal of this dissertation is therefore to investigate society's interest in the issue of morally justified behaviour during pregnancy. What exactly is this interest, if it exists at all, and how is it to be protected and/or enforced? To what extent is the argument from scarce resources morally relevant to this debate? Who exactly is to act on behalf of "society"? Is it the state, only the state, or other institutions as well? If so, which institutions, and how are their interests pertinent to this situation?

Following from this, the *fourth* goal of the dissertation is to establish who all the relevant parties are that carry moral responsibility in respect of FAS, particularly in

South Africa and what their responsibility might be. Is the individual pregnant woman the only party to be held morally responsible for the aberration of FAS? FAS does not come into existence, nor does it thrive, in a social and political vacuum. FAS can indeed also be seen as a social disease with roots in social practices and beliefs that are morally deeply problematic. Many factors that have been found to influence a woman's decision to drink have to do with her psycho-social and economic circumstances including alcohol's widespread availability and social acceptability. This suggests that society also has a role to play in FAS prevention. How realistic is it to expect morally upright and responsible behaviour from many women whose fundamental interest in life is often hardly more than access to a next plate of food or whose life circumstances are relatively bleak? When moral responsibility is conferred, it is required to also ask critical questions about the extent to which alcohol abuse is a societal condition. In turn, this raises questions about society's responsibilities towards these women. Again: is "society" here to be understood only as the state, or also as other institutions? If so, which institutions, and what are their responsibilities? Would the state be justified in interfering in the rights of a pregnant woman for the sake of protecting the future child/preventing FAS in children? Is criminalising her conduct justified? Should the state adopt coercive measures? What arguments can be made for and against state interference in a pregnant woman's rights? The choice is "between respecting a pregnant woman's right to decide what happens to her own body and protecting an innocent child from preventable harm. Who should the state protect: a woman's interest in remaining free from certain forms of state control" (Mathieu 1991) and interference or the "child's interest in having a decent quality life?" (Mathieu 1991). Even if a prospective mother has a moral responsibility toward

her fetus, should those be made legal ones? What are ethical social responses to prevent FAS?

The *fifth* and final goal of the dissertation is to establish if and whether children who have suffered prenatal harm and consequently have FAS can and should be allowed to institute delictual actions for prenatal harm against their mothers. This, in turn, raises the interesting question about the (possible) rights, not only of children, but also of fetuses, given the fact that, in South African jurisprudence, the fetus has no rights. In criminal law, the intentional killing of a fetus is not considered an act of murder because the fetus is not a person in law. This means that if someone “hits a pregnant woman” in the stomach “intending to kill” the fetus, and succeeds in doing so, the perpetrator can “be charged with assault of the woman but” not with murder for killing her fetus (Mathieu 1991:1-28). In South African jurisprudence, the issue of possible “rights of the fetus” can be interpreted in terms of the *nasciturus* fiction and the *Choice on Termination of Pregnancy Act* (No. 92 of 1996). Although the fetus has no legally enforceable rights in South Africa, the courts have recognised that situations that are prejudicial to the fetus may arise, had it been born alive at the time of the harm-causing event (Kruger & Skelton 2010). The law protects these potential interests of the unborn child, by employing a fiction (the *nasciturus* fiction) which allows for the fetus to be regarded as born if it will be to the fetus’s advantage (Kruger & Skelton 2010). A review of pertinent South African case law suggests that the fetus need not have any legal standing in order for the courts to recognise delictual actions for prenatal harm. Moreover, the conditions and limitations on a woman’s right to an abortion inherent in the *Choice on Termination of Pregnancy Act* suggests that at least some value is afforded to the fetus, as a pregnancy progresses and the fetus develops. Given this knowledge, might it therefore be legally possible that children with FAS

can and should be allowed to sue their mothers for damages for their disabled condition?

The implications and potential impact of the dissertation include:

- Contributing to existing ethics literature on the inter-related problems of alcohol abuse and drinking during pregnancy and consequently FAS in the South African context.
- Stimulating discussion and debate on the topic of moral responsibility for FAS rather than looking at these problems solely from a “rights-based” perspective.

5. Delimitation of Study Area

For purposes of this dissertation I use the term fetus to refer to the developing human being *in utero* at any stage in development prior to birth, since nothing morally significant seems to ride on my choice of terminology. I use the term “prospective mother” to include those pregnant women who intend to carry their pregnancies to term. I confine the discussion to competent adult women and therefore exclude those women who lack full decision making capacity due to for example their age or mental incapacity. Although the concept of future people is wide enough to embrace even those who have not yet been conceived, i.e. possible people, for purposes of this dissertation, I restrict its meaning to those who have been conceived and will, assuming pregnancy takes its normal course, in all likelihood, be born children. I therefore use the term future people synonymously with the term prospective child.

Although the focus of the dissertation is on the conduct on pregnant women, this should not be taken to mean that men do not have moral responsibility for and to their children, or that their behaviour cannot also be subject to moral scrutiny.

I restrict the term prenatal harm to those instances where a wrongful act that occurs prior to a child's birth, initiates a causal sequence that leads directly to harm the child (Matthieu 2007, Feinberg 1985; 1984). Joel Feinberg illustrates a case of prenatal harm in the following example, cited in Mathieu (1995): "A negligent motorist who runs over a pregnant woman may cause damage to the fetus that causes it later to be born deformed or chronically ill. Some time after birth that infant will have an active welfare interest in self-locomotion or health that may be harmed (doomed to defeat) right from the beginning. The child comes into existence in a harmed state caused by the earlier negligence of a motorist whose act initiated the causal sequence, at a point before actual personhood, that later resulted in the harm. The motorist's negligent driving made the actual person, who came into existence months later, worse off than she would otherwise have been. If the motorist had not been negligent, the child would have been undamaged" (Mathieu 1995:21). The outcome of a pregnancy and the health and welfare of fetuses and consequently, children, can be affected by a variety of events and lifestyle choices of parents, but perhaps most significantly by those of pregnant women. A woman's lifestyle choices may have beneficial and at the same time harmful effects on their fetuses and children. Particular changes in a pregnant woman's lifestyle such as taking proper nutrition, attending regular antenatal care and taking vitamins, can be beneficial to the health and welfare of her child (Phillips & Johnson 1977; Rosso 1981). At the same time, and setting aside the obvious harmful substances such as nicotine (Cnattinguis 1992; Shiono, et al. 1986) and alcohol (IOM 1996; Jones & Smith 1973; Streissguth, et al. 2004; 1994), there is

evidence that even ingesting seemingly harmless substances such as caffeine and even some common medicines can result in fetal damage and birth defects (Fortier, Marcoux & Beaulac-Baillargeon 1993; Konje & Cade 2008; LoBue 1983).

Broadly construed, the notion of prenatal harm includes both the use of substances which can *cause* harm and the refusal of therapies or interventions designed to benefit the fetus, in other words, those that can *prevent* prenatal harm, as for example in the case of a pregnant woman who refuses a blood transfusion, surgery or vitamin regimens. However, for purposes of this dissertation, I restrict usage of the term, prenatal harm to refer to those instances where a competent adult woman consumes alcohol during pregnancy.

The term harm may be construed in different ways, even to include birth as a harm. However, I distinguish prenatal harm from so-called wrongful life actions. The idea behind wrongful life actions is the controversial claim that the child has been wrongfully harmed by being born and that his or her existence is such that never having been born would be a preferable condition (Feinberg 1986; Pearson 1997; Strauss 1996; Steinbock 1986; Steinbock & McClamrock, 1994). Here, the child's claim is essentially that he or she would have been better off dead and, that by bringing him or her into existence; the parents have harmed them (Benatar 2006; Pearson 1997; Steinbock 1986; Steinbock & McClamrock 1994). In wrongful life, the central question is therefore whether one can be harmed by being born. On the other hand, prenatal harms can be defined as wrongful actions (or omissions) that lead to disability in a child. Actions for prenatal harm are thus better understood as actions for wrongful disability. The claim is not that one would be better off dead, but rather that one has been wronged because of a prenatal harm.

The focus of this dissertation is on FAS. This is not to deny the relevance of the range of other conditions falling on the spectrum of FASD. The reason that FAS is the focus relates to its seriousness and because the other conditions, namely, Alcohol-Related Neurological Defects (ARND) and Alcohol-Related Birth Defects (ARBD) are controversial diagnoses largely because they share features with other conditions such as attention-deficit disorder (ADD) and attention-deficit hyperactivity disorder (ADHD) in children (Coons 2013).

This is a philosophical study in the field of ethics, so it involves conceptual analysis, ethical reasoning and argumentation to evaluate ethical problems and questions to arrive at rational judgments about what the right or good action, policy or character disposition is. It does aim to make empirical claims based on findings from research. Instead research findings from secondary sources may be used to support normative claims.

6. Research Design and Methods

As this is a philosophical study it was conducted mainly by means of a comprehensive literature survey and study, as well as independent reflection and consultations with my supervisor, and other knowledgeable people in the field. As a dissertation on, specifically, ethics, it does not entail any empirical study, since ethics is a sub-discipline of philosophy, and philosophy is the study of concepts and ideas.

Ethics theses are normative in nature, i.e. they are concerned with what *ought* to (as in should) be, and not with what *is*. As such it does not seek to describe a particular state of affairs. Ethics does not draw conclusions from what is actually happening in the world because what is actually happening is not necessarily the same as what ought *to*

be happening. For this reason, this study did not involve controlled experiments or empirical methods of inquiry. Instead it considers an aspect of the moral consequences of reproductive choice by reviewing existing literature.

Empirical research is what ethicists may refer to as “descriptive ethics”. While descriptive ethics gives us insight into human behaviour and thinking, morally speaking, it does not tell us which actions are right, good, wrong, permissible, responsible, praiseworthy etc. This is not to say that empirical research is not useful in ethics; indeed empirical findings can give weight to moral arguments.

The typical research methods and standards applicable to philosophical research are employed. This primarily involves the interpretation and critical analysis of the most important texts to answer the research questions. My analysis of the relevant texts includes the definition and clarification of concepts, the identification and criticisms of assumptions, the analysis and evaluation of theoretical frameworks and the articulation of the most reasonable interpretation of significant concepts found in the sources.

Literature was sourced through utilising internet search engines such as Google Scholar, PubMed, Jstor and other academic search engines and by using keywords and phrases including, but not limited to, the terms drinking during pregnancy, fetal alcohol syndrome, fetal interests/rights, maternal-fetal conflict, pregnant woman, moral responsibility/obligation/duty, moral status, prenatal alcohol exposure, prenatal harm/injury, reproduction and pregnant woman autonomy/rights.

7. Ethics Statement

Since this is a normative study that uses secondary sources of data, ethical approval from a research ethics committee was not required.

8. Chapter Outline

In this chapter I offered an overview of this dissertation. The next chapter of this dissertation provides a description of the problem of maternal drinking during pregnancy. Chapter Three provides an analysis of the notion of moral responsibility and introduces the ethical issues and questions that maternal drinking during pregnancy gives rise to. In Chapter Four the questions pertaining to the nature and extent of a pregnant woman's moral responsibility for FAS are explored. Does she have a duty to abstain from alcohol? Should she avoid reproduction? Chapter Five explores the possible interests and ethical responses of the state to the problem of maternal drinking during pregnancy and FAS. Essentially it considers whether the state has any moral responsibility for the problem, and if it does, what that responsibility might entail. What arguments may be made for and against using coercion to prevent prenatal harm? Is the state justified in using coercion to prevent FAS? Finally, chapter six considers the question of whether children with FAS can and should be allowed to institute delictual actions against their mothers.

Chapter 2: Fetal Alcohol Spectrum Disorders

1. Introduction

In this chapter I present an overview of the problem of drinking during pregnancy. I describe the spectrum of disorders, collectively termed Fetal Alcohol Spectrum Disorders (FASD) that can occur in a child following prenatal alcohol exposure (PAE). The different clinical diagnoses and their symptoms under the umbrella of FASD are described along with the range of disorders and disabilities that can occur in affected individuals throughout the lifespan. This is followed by a presentation of the prevalence of FASD and woman's alcohol and contraceptive use in South Africa. Reasons why women drink and may abuse alcohol and the factors that increase a woman's likelihood of having a child with FASD are considered. The chapter concludes with a discussion of interventions to prevent FASD and the socio-economic costs of FASD.

2. The Effects of Prenatal Alcohol Exposure through Maternal Drinking During Pregnancy

Alcohol is a known teratogen, i.e. a substance capable of interfering with fetal development. If a woman drinks "during pregnancy, alcohol freely crosses the placenta into the blood and other tissues of the developing embryo or fetus" (Rendall-Mkosi, et al. 2008), and cause irreparable damage to the child. As Dorris (1994:122) explains: "... whatever a pregnant woman drinks, the baby she is carrying drinks, too. It is that simple... the fetus cannot eliminate alcohol nearly as quickly as the adult

body can; when a woman drinks, the concentration of alcohol in utero is higher than in the rest of her system, and it persists twice as long. By the time the woman feels pleasantly relaxed or euphoric, the fetus may be comatose”.

Drinking during pregnancy has been correlated with an increase in spontaneous abortion, fetal growth retardation, premature delivery, abruption placentae and breech presentations (DeVillie & Kopelman 1998). There are many critical periods during pregnancy when the fetus is vulnerable to alcohol's damaging effects (Rendall-Mkosi, et al. 2008). During the first trimester, alcohol can change the way in which cells grow and organise themselves and can result in abnormalities of the face, heart, brain, limbs and urogenital system. Neural defects can occur in severe cases. In the second trimester, prenatal alcohol exposure can lead to miscarriage, and in the third trimester, exposure to alcohol can impair overall fetal growth (Rendall-Mkosi, et al. 2008). The brain, which is thought to be most sensitive to alcohol's toxic effect, continues to grow throughout pregnancy and post-partum. “Damage done to the developing brain may result in a range of neurobehavioural problems in the face of normal intelligence” (Rendall-Mkosi, et al. 2008). Additionally, “the fetus exposed to high concentrations of alcohol in utero typically demonstrates a constellation of pre and postnatal problems including growth retardation, characteristic facial features and central nervous system (CNS) deficits” (Rendall-Mkosi, et al. 2008).

The adverse effects of maternal drinking during pregnancy have been postulated as far back as written records exist. One of the earliest observations of alcohol's negative effects during pregnancy was made by Aristotle who cautioned that “foolish, drunken and harebrained women most often bring forth children like unto themselves, morose and languid” (cited in Streissguth, et al. 1980). Another ancient warning about the potentially harmful effects of drinking during pregnancy can be found in a passage

from Judges in the Bible. In this story an angel appears to Manoah and his wife to announce to them that his infertile wife will “conceive and give birth to a son”, cautions her to “from then on to, take great care” and to “drink no wine or fermented liquor, and eat nothing unclean“ (Judges 13:7). The couple name their son Samson and he becomes well-known for his strength and wisdom (Abel 1999).

A specific medical link between alcohol and pregnancy outcomes “was not identified until 1899”, when “Dr William Sullivan compared the pregnancy outcomes of alcoholic prisoners with their relatives” and “found the infant mortality rate to be higher” among the alcoholic women (US Department of Health and Human Services 2007). In 1968 Dr Paul Lemoine and associates (Lemoine, et al. 1968), described the specific facial features and other symptoms associated with drinking during pregnancy. Doctors Jones, Smith and Ulleland (Jones, et al. 1973; Jones & Smith, 1973) are credited with coining the term Fetal Alcohol Syndrome (FAS) to describe the most severe condition that can occur in a child who was exposed to alcohol prenatally (Abel 1990; Armstrong 2003; Astley 2011).

Children who were exposed to alcohol prenatally are not affected in the same way and to the same extent. They can suffer a broad spectrum of disorders and disabilities that occur with variable severity, “depending on the dose, timing and conditions of exposure” (Streissguth & Bonthius 2006). There is no clear scientific consensus on the amount and pattern of alcohol exposure that is harmful to the fetus. “Risk from alcohol exposure varies between fetuses, even between fraternal twins with ostensibly identical exposure” (Astley 2011:18).

3. Fetal Alcohol Spectrum Disorder (FASD)

Fetal Alcohol Spectrum Disorder (FASD) is the umbrella term to describe the range and varying degrees of physical, cognitive and neurobehavioural effects or conditions that can occur in a child as a result of a woman's drinking during pregnancy (CDC 2005; Streissguth et al. 2004; Streissguth & O'Malley 2000). FASD is a "descriptive term rather than a diagnosis" (Zadunayski, et al. 2006). "Four diagnostic categories within the continuum of FASD" (May, et al. 2009), have been identified by the Institute for Medicine, "which represent the spectrum of damage from mild to severe. The specific diagnosis from most severe to less severe include: Fetal Alcohol Syndrome (FAS), partial FAS (PFAS) and alcohol-related neurodevelopmental disorders (ARND), and alcohol-related birth defects (ARBD)" (IOM 1996; Streissguth & O'Malley 2000; Zadunayski, et al. 2006). In the Western world, FAS "is the leading known preventable cause of intellectual disabilities" (Nuñez, Roussotte & Sowell n/d) and is a growing public health concern worldwide (WHO 1994).

FASD specific diagnostic guidelines that have been published include the Institute of Medicine (IOM) guidelines in 1996 (IOM 1996), the 4-Digit Code in 1997 (Clarren & Astley 1997), the Centers for Disease Control (CDC) FAS guidelines in 2004 (Bertrand, et al. 2004), and the Hoyme FASD guidelines in 2005 (Hoyme, et al. 2005). Each of the different FASD diagnostic guidelines or systems has strengths and limitations and raises questions concerning the clinical features that define each diagnosis on the FASD continuum (Astley 2011).

While each guideline requires a complete FASD evaluation to include an assessment of "four key diagnostic features" (Benz, Rasmussen, & Andre 2009) of FAS - viz. (i) growth deficiency, (ii) facial features, (iii) central nervous system (CNS) damage and,

(iv) prenatal alcohol exposure - there are differences among the systems that lead to variations in definitions and diagnostic criteria across the FASD continuum.

a. Growth deficiency

The different guidelines provide differing criteria for what constitutes growth deficiency for a FASD diagnosis, but children with FAS are typically significantly below average height and weight for their age (Chudley, et al. 2005; Hoyme, et al. 2005).

b. Facial features

Several specific facial abnormalities, that may be absent or mild in other FASD conditions, are visible in FAS children (Astley 2006). To meet the criteria for a FAS diagnosis, all of the diagnostic guidelines or systems require an individual to display three FAS facial features: (i) a smooth philtrum (flattened groove between the nose and upper lip), (ii) thin upper lips and (iii) shortened eye width (Chudley, et al. 2005; Hoyme, et al. 2005; IOM 1996).

c. Central nervous system (CNS) damage

Evidence of CNS damage may be “structural, neurologic and functional” (IOM 1996:72). Structural irregularities of the brain are observable through medical imaging techniques and may include microcephaly i.e. a smaller than normal head size (IOM 1996; O’Leary 2002). Other structural impairments must be observed through medical imaging techniques. If structural anomalies are not observed then neurological irregularities are assessed (IOM 1996). Functional irregularities are assessed when structural or neurological irregularities are not observed (Astley 2006; Chudley, et al 2005; IOM 1996). Various CNS domains have been identified that can determine a FASD diagnosis, including: general cognitive deficits (e.g. IQ), deviations in

executive functioning, memory, language, motor and social skills (Astley 2006; Hoyme, et al. 2005; IOM 1996).

d. Prenatal alcohol exposure

To meet the criteria for FAS, all of the above “three categories of problems must be present and non-alcohol related causes of the anomalies must be excluded” (Rendall-Mkosi, et al. 2008). Where possible, there must be confirmation of maternal alcohol consumption directly from the mother or a reliable collateral source e.g. health records. A “report of maternal drinking at the time of the pregnancy can help to confirm the diagnosis, but is not necessary. Whilst confirmation of maternal drinking is preferable, in a situation where it is impossible to obtain this information (for example if the mother is deceased and collateral information is not available) a definitive diagnosis of FAS can be made without confirmation of maternal drinking” (Rendall-Mkosi, et al. 2008).

The presence of the highly specific FAS facial features confirms a FAS diagnosis and distinguishes it from less severe conditions on the spectrum of FASD. Therefore, even in the absence of confirmed maternal drinking in pregnancy, the presence of the facial features can validate a FAS diagnosis. This is because only children with FAS have the distinct dysmorphic facial characteristics, caused by prenatal alcohol exposure.

For a diagnosis of Partial FAS (PFAS) “affected children must display typical facial features and abnormalities of either growth or CNS structure (or function). As in the case of FAS the diagnosis of PFAS can also be made without evidence of maternal alcohol use, however in both cases the clinical records classification should reflect this. Damage is present at the same level as FAS” (Rendall-Mkosi, et al. 2008), so while individuals with PFAS may look less like FAS, they have the same functional disabilities as someone with FAS.

Children diagnosed with alcohol-related neurodevelopmental disorder (ARND) display few or none of the FAS facial features and their growth and height may range from normal to minimally deficient, but they display significant CNS damage (Sampson, et al. 1997; Stratton, Howe & Battaglia 1996). An individual diagnosed with ARBD presents with a range of congenital abnormalities that are associated with prenatal alcohol exposure but has not the key features of FASD (IOM 1996). “A diagnosis of ARBD or ARND can only be made if there was confirmed heavy maternal alcohol exposure” (Rendall-Mkosi, et al. 2008).

The highly specific FAS facial phenotype makes FAS distinguishable from ARNB and ARBD. In the absence of the specific FAS facial features an individual’s outcome cannot be linked to prenatal alcohol exposure and FAS becomes indistinguishable from ARNB and ARBD. A particular problem with the diagnostic terms ARND and ARBD is that they imply that a person’s condition was caused by a woman’s drinking during pregnancy. But this presumption is problematic “because CNS abnormalities are not specific to (caused only by) prenatal alcohol exposure. There are many other known or unknown risk factors that may be partly or even fully responsible for the patient’s outcome. In the absence of the FAS facial phenotype, current medical technology has no ability to confirm or rule-out the etiologic role of alcohol in an individual patient” (Astley 2011:18). So while technology may reveal that there is damage it cannot prove or disprove that maternal drinking is the cause of the damage. When a FASD diagnosis is made the child and the birth mother - are directly implicated (Astley 2011). A positive diagnosis implies that the child’s mother possibly drank during pregnancy. These are however bold conclusions to make particularly in light of diagnostic challenges, and when a few of the FAS characteristics “are not specific to prenatal alcohol exposure and often manifest

differently across the lifespan” (Astley 2011:3). For example disorders, such as Williams-Beuren syndrome (WBS), also known as Williams syndrome (WS), have some symptoms like FAS (Martens, Wilson & Reutens 2008; Pober 2010). Williams syndrome is a rare genetic neurodevelopmental disorder characterized by among other features: a distinctive, "elfin" facial appearance, along with a low nasal bridge; developmental delay and cardiovascular problems that may be present at birth or may develop later in life (Martens, Wilson & Reutens 2008; Pober 2010).

4. Disabilities and Disorders in Individuals Exposed to Alcohol Prenatally

Children exposed to alcohol prenatally may suffer “a range of physical abnormalities including heart defects, skeletal defects, abnormalities of the renal system and visual and hearing problems” (Rendall-Mkosi, et al. 2008). Additionally, they display varying degrees of structural and neurological brain disorders and evidence of a complex pattern of behavioral, or cognitive abnormalities that are inconsistent with developmental level not explained by genetic predisposition, family background or environment alone” (May, et al. 2009). All children with FASD exhibit neurocognitive problems to a comparable degree (Kodituwakku, et al. 2001; Mattson, et al. 1997).

“Prenatal alcohol exposure can have numerous detrimental effects across” an affected individual’s “lifespan” (Coons 2013). Children with FASD suffer a range of lifelong (permanent) primary and secondary disabilities (Streissguth et al. 2004). Secondary disabilities are those disabilities that the child is not born with. “Secondary disabilities

include mental health problems, disrupted school experience, trouble with the law², inappropriate sexual behaviour, alcohol and drug abuse, difficulty with independent living, difficulty with employment and problems with parenting” (Rendall-Mkosi, et al. 2008:52); all of which arise as a consequence of primary disabilities, and “which can presumably be ameliorated through better understanding and appropriate intervention” (Rendall-Mkosi, et al. 2008).

“Primary disabilities are cognitive/intellectual deficits that reflect the CNS dysfunctions inherent in the FASD diagnosis” (Rendall-Mkosi, et al. 2008). They “are the direct cause of organic brain damage due to prenatal alcohol exposure” (Coons 2013), and create “problems with communication skills, memory, learning ability, visual and spatial skills, intelligence and motor skills” (Paton & Croom 2010). As a result of these primary disabilities, individuals with FASD are vulnerable for further difficulties (secondary disabilities) in life (Streissguth, et al. 2004).

The infant affected by alcohol usually presents with “feeding problems, irritability, unpredictable patterns of sleeping and eating and poor weight gain” which “make babies hard to care for and interferes with maternal bonding. The young child with FASD will often present with more specific signs – developmental delay, especially of speech; deficits in verbal learning, language, some aspects of visuospatial ability as well as overall intellectual ability, poor growth and behaviour abnormalities. Characteristic behaviour manifestations of FAS include hyperactivity, poor judgment, inability to appreciate consequences of actions, excessive friendliness, difficulty with sequencing, poor short-term memory and learning difficulties. Almost all of them suffer neurocognitive impairments of low social skills, emotional immaturity, memory

² According to a report, based on findings from a biennial snap survey conducted by the Department of Social Development between October and December 2010, and results from other studies, an assumption can be made that between 50% and 70% of minors who end up in jail have FAS (Williams 2012).

deficits, and most have a need for continued close supervision and support services” (Rendall-Mkosi, et al. 2008).

In the adolescent years many of the secondary disabilities begin to flourish (Coons 2013). “Many children with FASD do not legally qualify as mentally retarded and are likely to have problems accessing appropriate services. The child who appears physically normal and with an average IQ but who has behavioural difficulties, is more likely to be judged harshly than a child with intellectual impairment, and is more prone to the anger and frustration resulting from unrealistic expectations of parents and teachers who do not recognize or understand the neurological origins of the problem behaviours. The situation is aggravated if the mother and/or father are using alcohol in a chaotic family environment with negative impacts on the child with FASD and other family members” (Rendall-Mkosi, et al. 2008).

“Many challenges faced in adolescence continue into adulthood” (Coons 2013). The most common secondary disability in adolescents and adults with FASD is mental health disorder, “with clinical depression being the most prevalent diagnosis amongst adults with FASD” (Rendall-Mkosi, et al. 2008) and attention-deficit disorder (ADD) and attention-deficit hyperactivity disorder (ADHD) in children (Burd, Carlson & Kerbeshian 2007). Adults with FASD have constant difficulties and usually need help with financial management, “medical care, productive work and safe housing” (Coons 2013).

5. Prevalence of FASD in South Africa

The most widely used international summary prevalence estimate for FAS in the developed world is “1 to 1.5 cases per 1000 live births” (Klug & Burd 2003).

Population estimates in the US are that “1% of newborns fall into the spectrum of

fetal alcohol disorders” (Rendall-Mkosi, et al. 2008). FAS rates have been “estimated to be 18 to 141 times greater than those for the various populations in the United States” (May, et al. 2000). For urban populations, “the prevalence of FAS/FASD commonly reported in the literature for urban populations is 0.5 to 3 cases per 1000 live births for FAS and approximately 9 cases per 1000 live births for a FAS (Zadunayski, et al. 2006).

A national study to determine the prevalence of FAS/FASD in South Africa has not been conducted (May, et al. 2007; Olivier, et al. 2013; Urban, et al. 2015). However, prevalence studies have been conducted in 3 of the country’s 9 provinces - viz. Gauteng, the Western Cape and the Northern Cape – and mostly in “geographically and socio-economically localised” communities (Rendall-Mkosi, et al. 2008).

According to Urban, et al. (2015:1017), research has “almost exclusively targeted populations with 2 demographic characteristics: (i) residents of rural areas or small towns, and (ii) areas with populations comprising predominantly the mixed ancestry minority group, designated officially as ‘Coloured’”.

Rates of FAS/FASD in South Africa are reportedly amongst the highest in the world (Rendall-Mkosi, et al. 2008). Available data suggests that the rate of FAS/FASD is worryingly high in areas where research has been conducted. Surveys involving screening of Grade 1 school children found the prevalence to be more than 40 cases per 1000 children in the Western Cape and Northern Cape and more than 20 cases per 1000 children in Gauteng (Rosenthal, Christianson & Cordero 2005).

A study conducted in Gauteng among first-graders from four schools estimates the median prevalence of FAS to range from 19/1000 to 26.5/1000 (Rendall-Mkosi, et al. 2008). In the Western Cape, three studies were conducted in 1997, 1999 and 2002, amongst three different cohorts of Grade 1 children in the wine-producing town of

Wellington. The first study reported a prevalence of FAS of between 40.5 and 46.4/1000, the second a higher rate of 65.2-74.2/1000 and the third a combined FAS and PFAS rate of 68.0-89.2/1000 (Rendall-Mkosi, et al. 2008).³ These results reflect an upward trend which can partly be explained by the influence of increased diagnostic accuracy over the years.

Results from a more recent survey conducted in the rural town of Aurora, describe equally high rates of FASD among Grade 0 to 7 learners (Olivier, et al. 2013). “Of the 160 learners screened” for FAS/PFAS, “78 (49%) were screen-positive, of whom 63 (81.5%) were clinically assessed for FAS. The overall FAS/PFAS rate among the screened learners was 17.5%, with 16 (10%) children having FAS and 12 (7.5%) PFAS” (Olivier, et al. 2013). “High rates of stunting⁴; underweight and microcephaly were noted in all learners, especially those with FAS or PFAS” (Olivier, et al. 2013). “The median body mass index of children without” FAS/PFAS was 15.8 kg/m², “compared with a median 14.7 kg/m² in children with FAS/PFAS” (Olivier, et al. 2013).

In studies conducted in the Northern Cape towns of De Aar and Upington among first graders in 2001 and 2002, , an overall prevalence rate of 67.2/1000 of FAS, and PFAS of 20.8/1000 was reported (Rendall-Mkosi, et al. 2008; Urban, et al. 2008). The town of De Aar had the highest yet reported prevalence of 119.4/1000 of FAS and PFAS combined. A recent study by Urban and colleagues (2015) that compared the prevalence of FAS/FASD among Grade 1 school children in “2 suburbs with predominantly mixed ancestry and Black African populations” (Urban, et al.

³ Rendall-Mkosi, et al. (2008) explains “that in the third study the prevalence of both FAS and PFAS was determined and reported together which in part explains the higher prevalence”.

⁴ Stunting can be defined as a failure to grow optimally (height-for-age below -2SD from the median of the growth standard) and is usually caused by chronic undernutrition and/or infections. It is associated with poor physical and cognitive development in childhood and higher risks of cardiovascular and metabolic diseases in adulthood (Said-Mohamed, et al. 2015).

2015:1016) in the city of Kimberly found there to be no difference between the FAS and FASD prevalence in the two communities (Urban, et al. 2015:1018). “Stratified by school, ascertainment for FAS status was over 90% for 12 schools and over 85% for the remaining 2 schools” (Urban, et al. 2015:1018). A FASD diagnosis was made in “96 children (6.4%) including 83 (5.5%) with FAS, 6 (0.4%) with partial FAS, and 7 (0.5%) with ARND and none with ARBD” (Urban, et al. 2015:1024).

Prior to the study by Urban and colleagues (2015), only one study reportedly sought to determine the prevalence of FAS in the Black African population of South Africa (Urban, et al. 2015:1017). This study found a “1.9% prevalence of FAS among 830 first graders, with 1.7% prevalence in the subset of 414 learners from 2 predominantly Black African suburbs” in metropolitan Gauteng (Urban, et al. 2015:1017).

The findings from the various studies are particularly noteworthy because it shows that FASD is an issue in both rural and urban areas, as well as one in predominantly Black African communities, and suggests that the rates of FASD may underestimate the true magnitude of FASD for at least two reasons. Firstly, epidemiological studies to determine the rates of FASD have typically been conducted among Grade 1 school children, therefore excluding a large pool of people who are not in school or who are older and who may have a FASD (Clarren, et al. 2001; Little et al. 1990). Secondly, the difficulty and lack of uniformity in accurately diagnosing the range of FASD, means that some children may be misdiagnosed or not diagnosed. Given that the rates of FASD may be greater than research suggests, it is worth reflecting on the patterns and rates of drinking among pregnant women and alcohol and contraceptive use among women of reproductive age, in an effort to gain a more accurate picture of the magnitude and scope of FASD.

6. Alcohol Use among Pregnant Women in South Africa

In a “survey of pregnant women attending antenatal clinics (ANC) in three areas in the Western Cape – George/Oudtshoorn, Vredenberg/Saldanha and the Cape Metropole – 42.8%” of the women interviewed reported drinking alcohol during pregnancy (Rendall-Mkosi, et al. 2008). One quarter of the sample were classified as binge drinkers, i.e. had three or more drinks on one or more days in the past week, and almost one-third reported using “both alcohol and tobacco whilst pregnant” (Rendall-Mkosi, et al. 2008). Other localised studies in the province have documented equally high rates of drinking during pregnancy. In a farm-based study in the town of Stellenbosch, 41.6% of mothers reported drinking during pregnancy (Rendall-Mkosi, et al. 2000) and in the town of Wellington 96% of the mothers who reported current drinking i.e. have consumed alcohol in the month preceding the study were binge drinkers (May, et al. 2005; Viljoen, et al. 2002). In the Western Cape, mothers of children with FAS were found to have as much as “12.6 drinks per week” during pregnancy “compared with 2.4 drinks” for women in the control group (Ojo, et al. 2010).

In the Northern Cape, 66% of mothers or caregivers of FAS children reported current drinking as compared with 15% of control women (Urban, et al. 2008). Eighty two percent (82%) of mothers or caregivers reported drinking during index pregnancy compared to 19% of controls and mothers and caregivers reported almost twice as high rate of current drinking and concurrent tobacco use during pregnancy (Urban, et al. 2008).

7. Alcohol and Contraceptive Use among Women in South Africa

Although alcohol use among women in South Africa has traditionally been quite low, with high lifetime abstinence persisting among many women (Parry, Harker Burnhams & London 2012), population-based surveys and localised studies have documented high rates of alcohol use and heavy drinking among women aged 15 years and older (WHO 2004). If these women are sexually active and not using effective contraception then they may be at risk of having a FASD baby.

In 1998, as part of the country's first South African Demographic and Health Survey (SADHS 1998), one-fifth of the women (17%) reported that they were currently drinking. Sixteen percent (16%) of women reported that they were currently drinking and 32% of them reported binge drinking, usually over weekends. Approximately 10% of women are dependent on alcohol (WHO 2004) and alcohol dominates admissions as the primary substance of abuse and dependence (Freeman & Parry 2006; Parry, et al. 2005; 2003; Rataemane & Rataemane 2006; SACENDU 2011).

In a more recent national population based survey on alcohol use and drinking patterns 27.1% of women 15 years and older reported that they were currently drinking (Peltzer, Davids & Njuho 2011). Binge drinking was reported by almost 3% of the women (Peltzer, Davids & Njuho 2011). In a cross-sectional household survey, which aimed to compare the extent of, and assess factors associated with drinking among women of reproductive age in a rural site in the Western Cape and an urban site in Gauteng, 27% of women in Gauteng reported current drinking compared to 46% in the Western Cape site (Ojo, et al. 2010). Twenty percent (20%) of current drinkers in Gauteng were classified as high risk drinkers compared with 64% of current drinkers in the Western Cape (Ojo, et al. 2010).

Alcohol can impair one's judgment and "is increasingly being recognised as a key determinant of sexual risk behaviour" (Morojele, et al. 2006; Trigg, Peterson, & Meekers 1997), and "consequently an indirect contributor to HIV transmission in sub-Saharan countries" (Morojele, et al. 2006; WHO 2011). Findings from both qualitative and quantitative studies conducted in South Africa amongst adults aged between 22-45 years, suggest a relationship between drinking and risky sexual behaviour (Morojele, et al. 2004; 2006), including higher levels of unprotected sex (Fritz, et al. 2002; Mnyika, et al. 1997).

Alcohol use by sexually active women who are not using effective contraception can lead to unplanned or unwanted pregnancies. A nationally representative survey of South African 15-24 year olds, found that of the 6217 women interviewed, 67.9% (n=4066) reported having had sex in the year before the survey (MacPhail, et al. 2007). A little over 50% of these "sexually experienced women (52.2%) reported currently using contraception" (MacPhail, et al. 2007) and an equal number "reported ever having been pregnant" (MacPhail, et al. 2007). Of these, approximately "65% indicated that their pregnancy had been unwanted" (MacPhail, et al., 2007), however, "only 2.6% reported having accessed termination of pregnancy". The results of this study show that not all sexually active women use contraception, and even when pregnancy is unplanned and unwanted, only a few access abortion services.

The reported rates of drinking among women may be underestimated because women tend to underreport their drinking habits, either because female drinking is disapproved in some communities (Mphi 1994) or because of inadequate attention paid to making women feel at ease when asking sensitive questions (Gfroerer, Wright & Kopstein 1997). Moreover "questions about typical quantities of alcohol consumed can lead to underestimates as do questions about drinking standard drinks of alcohol"

(Peltzer, Davids & Njuho 2011). What constitutes a standard drink or standard drinking will of course vary depending on local customs. And although recent “recall methods encourage fuller reporting of volumes plus more accurate estimates of unrecorded consumption that places drinkers at risk of harm, they do not capture longer term drinking patterns” (Peltzer, Davids & Njuho 2011).

8. Determinants of and Risk Factors for Drinking During Pregnancy and FASD

Research indicates that some women drink alcohol when they are pregnant, thereby placing their fetuses at risk for alcohol’s damaging effects and consequently FASD in their children. But while drinking during pregnancy is a necessary condition for having a FASD baby, it is not by itself a sufficient condition for having a FASD baby. The spectrum of disorders that can occur in a child exposed to alcohol prenatally suggests that, because children are not affected in the same way, there must be other factors, beyond merely drinking during pregnancy or prenatal alcohol exposure to alcohol, influencing the nature and extent of damage suffered by the child.

“A woman’s drinking during pregnancy does not occur in a vacuum” (Coons 2013). Women from all socio-economic groups drink for a host of reasons, so the question is then not so much *who* drinks during pregnancy but rather *why* women do drink during pregnancy thereby risking FASD in their children. The motivation and urge to drink alcohol is complex and there is no single reason for why some women drink during pregnancy and the various manifestations of FASD features. Factors that play a role in contributing to a woman’s drinking during pregnancy and consequently the risk of FASD include alcohol’s relative availability and acceptability and the woman’s drinking pattern, nutrition, genetics and psycho-social and cultural context (Coons

2013; Katwan, Adnams & London 2011; May, et al. 2005; Ojo, et al. 2010; O’Leary 2004; 2002; Urban, et al. 2015; 2008; Viljoen, et al. 2002; 2001).

8.1. Social acceptability and availability

Alcohol is not a banned or illegal substance in South Africa, although its sale, advertising and use are subject to regulation. Anyone aged 18 years and older can purchase alcohol in terms of the *Liquor Act* (2003). Despite restrictions on the use and sale, through time and location restrictions, alcohol is widely available in the formal and informal sectors to consumers in both rural and urban areas (NAMC 2002; Parry & Bennets 1999). According to Parry and Bennets (1999) the informal sector comprises approximately 200 000 liquor outlets (largely shebeens⁵) and hundreds of home brewers of traditional beer. Based on retail sales, in 1997, it was estimated that there were approximately “22 900 licensed outlets”, mainly comprising “liquor stores, restaurants and taverns (Setlalentoa, et al. 2010). The number of liquor outlets operating in the country has since increased (Parry & Bennets 1998) and South Africa is considered one of the highest consumers of pure alcohol per adult capita in the world (WHO 2011). In terms of recorded alcohol consumption the country ranks 47th out of 189 countries, with a per capita consumption of 7.81 litres (WHO 2004). When this is added to the unrecorded consumption of alcohol - such as traditionally or home brewed beverages, smuggling, and beverages with alcohol below the legal definition of alcohol such as mouthwashes - the total rises to over 10 litres (WHO 2004), and when that figure is adjusted for the number of current drinkers aged 15 years and older, the figure rises to approximately 20.1 litres of pure alcohol per capita (Rehm, et al. 2003). Of 35 countries surveyed, the 2004 WHO *Global Status Report on Alcohol*

⁵ Shebeens are usually illegal unregulated establishments, whereas taverns refer to legal and regulated establishments.

ranks South Africa as having the highest reported figure of alcohol dependence (alcoholism) amongst the adult population: 27.8% of males and 9.9% of females (Freeman & Parry 2006; Parry, et al. 2005; WHO 2004). Alcohol dominates admissions as the primary substance of abuse and dependence (Parry, et al. 2005; 2003; SACENDU 2011) and “is consistently the substance of abuse in people receiving help for substance related problems” in the country (Freeman & Parry 2006).

There are currently no binding regulations on alcohol advertising, sponsorships, sales promotion and product placement (WHO 2011), however the Department of Health is considering passing legislation in the form of the *Control of Marketing of Alcoholic Beverages Bill* (2013), which will totally prohibit the advertising and promotion of alcoholic products in the country (Paton 2012; Short 2012). A body of evidence suggests that several forms of alcohol advertising promotes and increases consumption (Ellickson, et al. 2005; Parry, Harker Burnhams & London 2012; Snyder 2006). In South Africa, the alcohol industry reportedly spends over R 350 million on above-the-line advertising alone, with many tens of millions spent on below-the-line advertising such as sports sponsorships and promotions (Parry 2005).

Up until 2007, when new packaging regulations were gazetted to regulate the packaging of alcoholic beverages in the country, cheap, poor quality wine with a high alcohol concentration was being sold in inferior packaging to the general public in massive volumes (McLoughlin 2007; NAMC 2002). Nowadays, in terms of the *Regulations to the Foodstuffs, Cosmetics and Disinfectants Act* (1972), container labels for alcoholic beverages must contain at least one of seven health messages or warnings that includes one that reads “Drinking during pregnancy can be harmful to your unborn baby”. Driving a vehicle with a blood-alcohol concentration of 0.05%

and higher is criminal (Thakali 2011) but drinking during pregnancy is not, although there has been a contentious proposal from the Gauteng Provincial Government to effectively ban the sale of alcohol to pregnant women (*Gauteng Liquor Bill* 2012). In terms of the proposal, a licensed liquor trader is not allowed to sell, supply or give alcohol to a pregnant woman and is required to visibly display in the premises a notice that informs consumers about the dangers of drinking during pregnancy. The proposal makes no distinction between on-premise and off-premise sales of alcohol.

Drinking is socially acceptable and there is generally very little criticism of people who drink. In some groups and on some occasions drinking - sometimes even to the point of intoxication - is encouraged and even expected. Because alcohol supposedly has a “mystique” that non-alcoholic beverages lack, alcohol is widely used in traditional rituals and celebrations, such as champagne toasts at weddings, birthday parties and graduation ceremonies. In some Christian churches, alcohol is also used as part of communion, where it is symbolic of the blood of Jesus Christ.

“Many people, especially youth, may be, or feel, pressurized to drink alcohol as this is regarded as the social norm or the norm of a particular age or social/cultural grouping. The pressure to conform, especially amongst youth, is a well-documented psychological phenomenon. People may be (or fear they may be) excluded from or ostracized by the group if they do not partake in alcohol” (Freeman & Parry 2006:4). Young people, in particular, may therefore feel the need to drink and do so in harmful ways to show that they are part of the group so as to avoid exclusion. Indeed some people may start drinking “ignorant of the facts regarding the” impact and “effects of alcohol” (Freeman & Parry 2006).

In many situations, alcohol may be used as a social lubricant to help people who may be uncomfortable at social events to relax, and make it easier for them to socialise.

Alcohol is the tool that enables them to lose their inhibitions or disinhibit their defenses and facilitate ‘good company’ (Freeman & Parry 2006). “Sharing an alcoholic drink with other people” is therefore seen to be a means to promote “bonding and connectedness among consumers often not gained through sharing non-alcoholic drinks” (Freeman & Parry 2006). Many people who enjoy consuming alcohol, may also enjoy the state of being intoxicated by its effects; although perhaps in varying degrees, ranging from mild intoxication to being “totally smashed” or “motherless”. For some drinkers, “intoxication is not maintained unless additional alcohol is consumed. This may lead to more consumption and to states of drunkenness not necessarily intended when starting to drink” (Freeman & Parry 2006). In some groups getting drunk is almost like a badge of honour, even amongst women. Whereas some groups shun the idea of drinking to a state of intoxication, in other groups, the more you drink, the more you are accepted. Being able to drink “more than anyone else” or more quickly than anyone else is “often regarded as admirable qualities” (Freeman & Parry 2006). Among men, excessive drinking is usually seen as an indication of one’s “strength and manliness” (Freeman & Parry 2006). Hence people say things like ‘He sure can hold his liquor’, meaning he can drink a lot. Nowadays however this applies equally to women. “With changing gender roles some women also prove themselves with binge drinking patterns” (Freeman & Parry 2006). So one may equally hear things like ‘She can drink like a man’, which is actually meant as a compliment.

8.2. Drinking patterns

The quantity, regularity and timing of maternal drinking can significantly impact the development of key FASD features. Despite there being agreement that alcohol is a

teratogen, there is no clear consensus about the precise pattern of drinking that is dangerous (IOM 1996). Although a body of literature suggests that “light” or “moderate” drinking during pregnancy is not linked to detrimental impacts on mental or behavioural development during early childhood (Eriksen, et al. 2012; Kelly, et al. 2013; 2009; O’Leary, et al. 2010; Polygenis, et al. 1998; Robinson, et al. 2010; Wilkie 1997), this remains contestable.

The *Food-Based Dietary Guidelines for South Africa* do not clearly stipulate how much alcohol constitutes “moderate” drinking (Van Heerden & Parry 2001) but in the United States of America (USA), it is defined as having up to 1 drink per day for women and up to 2 drinks per day for men (US Department of Agriculture 2010; US Department of Health and Human Services 2009). Although a woman’s drinking pattern, her overall state of health and a range of socio-economic, biological and environmental factors play a role in FASD, no amount of alcohol or drinking pattern can be said to be safe. Genetic examinations in mice suggest that even moderate amounts of exposure to alcohol can cause significant modifications (Laufer, et al. 2013).

On the other hand, regular heavy drinking during pregnancy is an established primary risk factor for FAS (Jones & Smith 1973; May, et al. 2005; Ojo, et al. 2010; Urban, et al. 2015; Viljoen, et al. 2002). The WHO defines heavy drinking as “a pattern that exceeds some standard of moderate drinking defined in terms of exceeding a certain daily volume or quantity per occasion” (WHO 1994) - or more specifically, socially acceptable drinking. “Socially acceptable” or “social drinking” is however “not necessarily moderate drinking” (WHO 1994), because in some societies it may be socially acceptable to drink to the point of intoxication (WHO 1994). According to the WHO (2004) people who use alcohol in harmful ways fulfil any of the following

criteria: they match criteria for alcohol abuse or dependence (“alcoholism”) or engage in periodic binge drinking or regular heavy consumption.

In the 1990s, the World Health Organization published diagnostic guidelines for defining alcohol abuse in the *ICD-10 Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines* (WHO 1993). ICD-10 defines two alcohol use disorders – (a) harmful use and (b) dependence syndrome. Harmful use is defined as, “a pattern of psychoactive substance use that is causing damage to health. The damage may be physical (e.g. hepatitis following injection of drugs) or mental (e.g. depressive episodes secondary to heavy alcohol intake) (WHO 1993). The WHO explains that “harmful use commonly, but not invariably, has adverse social consequences”, but that “social consequences in themselves”, are not sufficient to justify a diagnosis of harmful use” (WHO 1993).

Another pattern of harmful alcohol use described by the WHO is dependence. “Dependence syndrome is a cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value. A central descriptive characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take psychoactive drugs (which may or may not have been medically prescribed), alcohol, or tobacco” (WHO 1993). Usually, “a definite diagnosis of dependence is only made if three or more of the following have been present together at some time during the previous year: (a) a strong desire or sense of compulsion to take the substance; (b) difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use; (c) a physiological withdrawal state when substance use has ceased or been reduced” (WHO 1993). In South Africa the legal definition

can be found in the *Prevention of and Treatment for Substance Abuse Act* (No. 70 of 2008), which defines alcohol abuse as the sustained or sporadic excessive use of alcohol, but does not seem to specify how we are to understand “excessive use”.

High rates of binge drinking among women and pregnant women have been documented in studies conducted in South Africa. Binge drinking is typically defined in these studies as having had three or more alcoholic drinks on one occasion for females and five or more drinks on one occasion for men (Croxford & Viljoen 1999; Department of Health 1998; Peltzer, Davids & Njuho 2011; Reddy, et al. 2003).

In the 1998 South African Demographic and Health Survey (SADHS), 32% of the 16% of women who reported current drinking were classified as binge drinkers (Department of Health 1998) and “10% of women screened positive for alcohol problems” (Rendall-Mkosi, et al. 2008). A cross-sectional household survey conducted in a rural site in the Western Cape and an urban site in Gauteng revealed that of the 27% female drinkers who reported current drinking in Gauteng, 20% were high risk drinkers compared to 64% of the 46% current female drinkers in the Western Cape (Ojo, et al. 2010). High rates have also been documented in surveys involving schoolgirls: in Port Elizabeth (Eastern Cape) 43% reported binge drinking and in Cape Town (Western Cape) and Durban (KwaZulu-Natal), the figures stood at 18.7% and 28.7% respectively (Rataemane & Rataemane 2006). One reason for the high rates of heavy drinking and consequently FASD in some communities, notably those in the Western Cape and Northern Cape can be historically traced back to a system that used alcohol as a form of social control and to induce and secure labour on farms.

8.3. Historical explanations

When the Dutch first settled in the Cape in the 1600s, the “dop system”⁶ was introduced in order to induce and secure labour on farms (La Hausse 1988; McKinstry 2005.). In terms of this system indigenous “farm workers were partially paid in alcohol (typically wine) for their labour” (Scully 1992). The “system became entrenched during the 18th century – the time of slaveholding – when poor quality wine was given, as a condition of service, at regular intervals during the working day and on weekends to farm workers and children as young as 12 years. Wine was cheaper than wages and over time the system also became a profitable mechanism for disposing poor quality wine” (Rendall-Mkosi, et al. 2008:23).

By the end of the 19th century, the British colonial government believed that alcohol had become such a serious social problem that it introduced laws to control drinking. Because they believed that alcohol made Africans disobedient (La Hausse 1988), the government sought to restrict access to alcohol by Africans. The *Native Beer Act*, which was passed in 1909 in Natal (now KwaZulu-Natal), became the model legislation throughout South Africa. In terms of this law, the legal consumption of alcohol by Africans was allowed only within municipal beerhalls (Parry & Bennetts; 1998; 1999). African people were totally banned from drinking in bars and other public areas. La Hausse (1988) postulates that this was “based on the idea that it was wrong for natives to have their own beer hall (Setlalentoa, et al. 2010). One exception to the law was made for mine workers, who were “legally permitted to brew and then distribute beer” among workers at the end of their shift and on condition that it was “consumed on the mine premises” (Rendall-Mkosi, et al. 2008:25). Because its

⁶ The word “dop” is Afrikaans and means alcohol or drink.

consumption off mine premises was illegal, “the system ensured that workers not only returned to work but also returned sober” (Rendall-Mkosi, et al. 2008).

The restrictions placed on the sale and consumption of alcohol to Africans led to a proliferation of homebrewed alcoholic beverages (especially sorghum beer) and small-scale illegal outlets that served them. These activities provided many people with a source of income and continue to play an important role in the economy. According to Parry and Bennetts (1998) the production and sale of homebrewed liquor represented an act of defiance by Africans against the restrictions placed on them. “Government controlled beerhalls and illegal shebeens were central to social networks and featured strongly as means of both control and resistance in both pre- and apartheid South Africa” (Rendall-Mkosi, et al. 2008).

Although the dop system has been outlawed in South Africa, the system reportedly persisted in the 1990s and there is evidence that variations of the system continue to operate in farming communities. For example, in a study by London (2000) almost one-fifth (19.4%) of farmworkers in the deciduous fruit industry “reported current use of the dop system” (London 2000), and nearly 50% reported having experienced the system on “one or more farms in the past” (London 2000). The study found that workers with “past experience of the system were 10 times less likely to be abstainers than colleagues without exposure to the system” (Gossage, et al. 2014). Undoubtedly therefore the dop system, together with “other coercive and paternalistic labour and social control” practices played a significant role in influencing people’s decision to drink and in shaping drinking patterns in the country (Rendall-Mkosi, et al. 2008). Collectively these measures influenced the racially aligned drinking patterns and preferences in the country (Mager, 2004; McLoughlin, 2007). The dop system may have been outlawed but it has left a devastating legacy. Farm workers’ experiences of

the dop system have “been linked to numerous negative health outcomes including greater poverty” (Rendall-Mkosi, et al. 2008) and FAS (London, Sanders, & Te WaterNaude 1998b; London, et al. 1998a; May, et al. 2007), and today problem drinking is deeply ingrained in the communities (May, et al. 2005). Even today, despite the low wages that they earn working on farms, farm workers continue to spend money on alcohol and often liquor outlet owners will extend credit to the workers, effectively ensuring that they are in constant debt. The dop system “evolved into a system of” institutionalized “alcohol use and social control” and created a heavy dependence on alcohol, and which consequently resulted in generations becoming trapped in “cycles of poverty and heavy alcohol use” (Rendall-Mkosi, et al. 2008).

8.4. Psychological explanations

Alcohol is controversial largely because it is no ordinary commodity. Alcohol has psychoactive properties. It affects a person’s brain and influences an individual’s behaviour in a way that ordinary commodities, like for example bread and milk do not do. Many people find their life circumstances abysmal and intolerable and drink to reduce tension or anxiety or to enhance feelings of wellbeing. Jellinek (1971) believes that because alcohol is thought to relieve tension or stress, drinkers tend to drink more and more frequently. Tolerance thus develops over time and individuals may then drink only to become intoxicated. In South Africa women have reported drinking during pregnancy because they were depressed, stressed or bored (May, et al. 2005; Morojele, et al. 2006; Rouleau, et al. 2003; Urban, et al. 2008; Viljoen, et al. 2002; Vythilingum, et al. 2012).

8.5. Socio-economic status and nutrition

Having low socio-economic status, including living in poverty (May, et al. 2005; Viljoen, et al. 2002), and having a low level of education (Rendall-Mkosi, et al. 2008), are additional factors for abusing alcohol and consequently that increase the probability for having a FASD child. This is because poverty is thought to exacerbate stress and heavy drinking and consequently increases the odds of unprotected sex. Women who are poor are also likely to have poor nutrition or be undernourished. Research is increasingly reporting the effect of poor nutrition on pregnancy outcomes (Keen, et al. 2010; May, et al. 2009; 2005; Urban, et al. 2008). Alcohol can interfere with maternal nutrition and with the digestion and absorption of food (Keen, et al. 2010) thereby displacing other dietary nutrients. Undernourished or smaller women may be at increased risk of having a FASD baby because they attain higher blood-alcohol concentrations than women who drink that same amount but are adequately nourished or have a larger body (Chudley, et al. 2005).

8.6. Genetics

Genetic factors also play a role in FASD, particularly with regards to alcohol metabolism for at least two reasons (Coons 2013). Firstly, this is because not all children that have been exposed to alcohol prenatally display clinical effects. And, secondly because studies on animals “have shown that there are strain variances that are determined by differences in genetic background” (Coons 2013).

Within families there is a high recurrence rate and risk of FASD (Chudley, et al. 2005). "For example research has documented that siblings of children with FAS have an increased risk of FAS at 170 per 1000 among older siblings and 771 per 1,000 in younger siblings compared to 1.9 per 1000 in the population as a whole” (Coons

2013:17-18). Other studies have shown that identical twins tend to be affected in more similar ways by prenatal alcohol exposure compared to non-identical twins thus suggesting a genetic component to FASD expression (Astley 2011; Coons 2013). It is postulated that “variations in the functions of particular gene products or enzymes that may lead to alcohol cravings and alcoholism may increase a woman’s susceptibility to drink during pregnancy” (Coons 2013:18).

Additionally “emerging evidence suggests that some genes found in mothers, and others found in mothers and/or their children, may be protective by influencing alcohol metabolism and by being associated with lower BAC for the same amount of alcohol consumed in individuals who have the genes compared to those who do” (Rendall-Mkosi, et al. 2008:21). According to May and colleagues (2009) individuals “who are lacking in alcohol dehydrogenase (ADH) and aldehyde dehydrogenase (ALDH) metabolism tend to drink less and therefore have a lower risk” of having “children with FASD” (Coons 2013). Concomitantly, women “who have more ADH and ALDH may be at an increased risk of having children with FASD” (Coons 2013:18). However, despite the role of genetics in maternal drinking and FASD, it is important to note that any amount of drinking during any stage in pregnancy is potentially harmful to the fetus and consequently the child (Coons 2013).

Other determinants of drinking during pregnancy and FASD include: being raised in an environment where heavy drinking is present (Astley, et al. 2000; May, et al. 2005; Rouleau, et al. 2003; Viljoen, et al. 2002), being exposed to “abusive and dysfunctional families” (Rendall-Mkosi, et al. 2008) and having a partner or family member who drinks in harmful ways (Bakhireva, et al. 2011), and polydrug use, particularly concurrent drinking and smoking during pregnancy (Ojo, et al. 2010; O’Leary 2004; 2002; Urban, et al. 2008; Vythilingum, et al. 2012).

9. Prevention of FASD

There is no cure for FASD, and although treatment can ameliorate some of its effects, affected children may suffer a range of permanent disabilities. FASD is 100% avoidable, if women stop drinking if they are or plan to become pregnant. However, changing behaviour – be it to abstain or reduce alcohol intake – is not as straightforward in practice as it may seem in theory. This has much to do with the reasons women drink and understanding the range of factors that make some women more likely than others to continue drinking during pregnancy and therefore risk miscarriage or having a FASD child. The fact that a range of variables, beyond maternal drinking or prenatal alcohol exposure, have a role to play in FASD suggests that a multifaceted approach aimed at the level of the individual and population is more likely to be successful than any single strategy by itself (WHO 2005). Despite the general difficulties involved in efforts to change behaviour, and the uncertainty about their efficacy and cost-effectiveness, a number of strategies discussed below - some of which have an evidence base of demonstrated efficacy - can be used to reduce or prevent maternal drinking during pregnancy and consequently FASD (Wilson & Wilson 2013).

9.1. Screening for alcohol use and brief interventions

Screening for alcohol use is critical in assessing the severity of use and need for brief interventions. A number of validated screening tools are available to assist in identifying women who may be abusing alcohol and at risk of having a child with FASD. These include: the AUDIT (Alcohol Use Disorders Identification Test), T-

ACE and TWEAK tests. The T-ACE and TWEAK tests were developed specifically for use with pregnant women (Bradley, et al. 1998; CDC 2009; Chang 2001; Elliott, et al. 2008).

The TWEAK is a five-item screening tool that includes the following set of questions (Chan, et al. 1993):

- i. Tolerance: How many drinks can you hold?
- ii. Worried: Have close friends or relatives worried or complained about your drinking in the past year?
- iii. Eye opener: Do you sometimes take a drink in the morning when you get up?
- iv. Amnesia: Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?
- v. K(C): Do you sometimes feel the need to cut down on your drinking?

Scores are calculated as follows: A positive response to the question on Tolerance and Worry yields 2 points each; whereas an affirmative reply to question E, A, or K scores 1 point each. A total score of 2 or more points on the TWEAK indicates a positive outcome for pregnancy risk drinking (Chan, et al. 1993).

The instrument shown to be the most sensitive (indicating true exposure) in the periconceptual populations is T-ACE (Bradley, et al. 1998; Sokol, et al. 1989). The T-ACE test consists of the following four questions:

- i. Tolerance: How many drinks does it take to make you feel high?
- ii. Annoyance: Have people annoyed you by criticizing your drinking?
- iii. Cut down: Have you ever felt you ought to cut down on your drinking?
- iv. Eye opener: Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

Scores are calculated as follows: a reply of More than two drinks to question T is considered a positive response and scores 2 points, and an affirmative answer to question A, C, or E scores 1 point, respectively. A total score of 2 or more points on the T-ACE indicates a positive outcome for pregnancy risk drinking (Sokol, et al. 1989).

The purpose of brief interventions is to motivate individuals with “a real or potential alcohol problem to do something about it and are “characterised by their low intensity and short duration” (WHO 2001). Brief interventions “usually comprise one to three sessions of counselling and education” (Freeman & Parry 2006; U.S. Department of Health & Human Services 2009), and have been found to be effective in health care settings (Bient, Miller & Tonigan 1993; D’Onfrio & Degutis 2002; Whitlock, et al. 2004; Wilk, Jensen & Havighurst 1997) and in community (O’Connor & Whaley 2007) and college settings (Larimer & Cronce 2002). In the health care setting it may provide opportunities for medical professionals to educate patients about the potential harms of drinking during pregnancy, and to their use of medication and other aspects of treatment in addition to referring them for treatment and rehabilitation and other support services (WHO 2001).

A few randomised controlled trials that sought to assess the success of brief interventions coupled with the provision of contraceptive services and that involved partners of women who drink reported reduced rates of maternal drinking (Chang, et al. 2005; Floyd, et al. 2007; O’Connor & Whaley 2007). For example, a randomized trial of a brief intervention, that entailed the provision of four counselling sessions and contraception services to women at high risk for having a child with FASD, found the odds of reducing the risk to be higher in the intervention group over the information (control) group (Floyd, et al. 2009). Another randomized trial of a brief intervention

targeting pregnant women in the third trimester, reported results that showed women in the brief intervention group to be less likely to continue drinking during pregnancy than women in the assessment only group by the third trimester (Elliott, et al. 2008:59; Floyd, et al. 2009). And a “2005 randomized study of pregnant women found that a single brief intervention counselling session that included partners” to be effective in reducing drinking among the heavier drinkers in the treatment group (Floyd, et al. 2009).

9.2. Treatment and rehabilitation services

While screening and brief interventions may have success at getting some women to abstain or cut down on their drinking, the effectiveness of these strategies is doubtful if the woman is dependent on alcohol or cannot easily stop drinking. So while some women may act on advice to stop drinking if they are or plan to become pregnant, others may ignore the advice, either because their circumstances are not conducive to them abstaining or because they are “alcoholic”. For alcoholics behaviour change may be a difficult if not almost impossible thing to do on their own, and as Abel (1998:14) explains, there is little reason to think that women alcoholics will be any different from the drunk driver who, despite its unlawful status and the risk involved, continues to drink and drive. What Abel (1998) is suggesting is that the pregnant alcoholic woman is an alcoholic woman who happens to be pregnant, rather than a woman who happens to become alcoholic during pregnancy. By Abel’s (1998) account, it is irrational to expect pregnant women who are alcoholics to simply abstain, even if they are aware of the dangers of drinking during pregnancy and especially if appropriate treatment and rehabilitation services are neither available nor accessible to help them to do so. In the absence of treatment and rehabilitation

services, prevention efforts are likely to have little, if any, impact on the drinking habits of women at risk of having a child with FASD. Access to alcohol and other drug use treatment programmes designed for women that include support services, can result in changes in alcohol and other drug use, mental health symptoms and birth outcomes (Ashley, Marsden & Brady 2003).

In view of the many factors that foster alcohol abuse and dependence, treatment programmes must make systematic use of a combination of approaches (Moos & Finney 1983) that may include cognitive behavioural therapy (CBT), the use of pharmacological agents and community programmes such as Alcoholics Anonymous (AA) to help alcoholics overcome abuse and dependence (Sue, Sue & Sue 1994; NHS 2011). Cognitive behavioural therapy (CBT) is a form of counselling or therapy that emphasizes a problem solving approach to alcoholism (Sue, Sue & Sue 1994). Among the many CBT strategies devised to treat alcoholism and other substance-abuse related disorders is aversion therapy, relaxation techniques and motivational approaches. Aversion therapy is based on classical conditioning principles and has been used for many years. It is a process by which sight, smell or taste of alcohol is paired with a noxious stimulus. For example, alcoholics may be given painful electric shocks while drinking alcohol, or they may be given agents that induce vomiting (*emetics*) when they get the urge to drink or after smelling or tasting alcohol (Cooper, Russell & George 1988). Because people often consume alcohol to cope with emotional problems, behavioural techniques such as relaxation and stress management have also been explored in the treatment of alcoholism as has a motivational approach in which alcoholics are helped to define and accomplish important and realistic goals (Cooper, Russell & George 1988; Cox & Klinger 1988, NHS 2011).

A range of medications can also be prescribed to prevent drinking. These include: (i) Acamprostate, which has been “shown to lower relapse rates” in alcoholics; (ii) Disulfiram or Antabuse, which produces unpleasant side effects if a person drinks within 2 weeks after taking the drug”, and (iii) Naltrexone or Vivitrol, “which decreases alcohol cravings” (A.D.A.M 2011). None of these drugs can however be used by pregnant women or drinkers who have certain medical conditions (A.D.A.M. 2011), thus underscoring the need for psychotherapy.

9.3. Contraception and abortion services

Aside from not drinking during pregnancy one sure way to avoid FASD is for women drinkers to simply avoid pregnancy and birth altogether. If women who drink do not get pregnant or do not give birth, then there is no fetus or child at risk of FASD. FASD can also be prevented if sexually active women who do not wish to become pregnant use effective contraception. Some people may however elect not to use contraception, for whatever reason, or their choice of contraception may fail, resulting in unwanted or unplanned pregnancy. Some pregnant women may not wish to remain pregnant and consequently become parents and they should have access to abortion services. I am not suggesting that women should (have a duty to) use contraception or that they should (have a duty to) selectively abort their fetuses; only that they should have the right to terminate a pregnancy, especially ones they do not want. Even if they abort for reasons of possible disability in their child, this is not a good reason for preventing them from having an abortion.⁷ One can have a right to (not) reproduce but it is debatable whether one has a duty to (not) reproduce. Moreover, it seems

⁷ In South Africa, under the *Choice on Termination of Pregnancy Act*, women may terminate their pregnancies for a host of reasons, including if their future child is likely to be disabled.

unreasonable to deny women the option of terminating a pregnancy, particularly since pregnancy and birth prevention may be less costly than those of FASD.

9.4. Public education

According to the WHO (2002), the most successful approaches to change drinking behaviour and attitudes concentrate not only on trying to change the drinker's behaviour directly, but also on influencing the community environment around the drinkers. Programmes aimed at the wider community can serve to increase levels of awareness of alcohol abuse and the possible negative effects associated with maternal drinking during pregnancy (Glik, et al. 2008). But while it is generally recommended that programmes “to prevent FASD should include universal or community-level measures, little has been done to document their effectiveness” (Chersich, et al. 2012). One local study has however sought to determine if the prevalence of FASD “would be reduced by universal interventions aimed at raising community and health worker awareness of the harms of maternal drinking and to shift-related social norms” (Chersich, et al. 2012).

Findings from a study conducted in two towns in the Northern Cape suggest that “universal prevention might reduce FASD by 30% and have population-level effects” (Chersich, et al. 2012). The study took place from 2003 to 2006 in De Aar and from 2005 to 2010 in Upington and occurred in three phases (Chersich, et al. 2012). Phase one involved conducting “a baseline assessment of FAS and PFAS prevalence among cohorts of infants, born in a 1-year period” (Chersich, et al. 2012); maternal alcohol use; women's “knowledge and attitudes to alcohol use; and the amount of exposure to the intervention” (Chersich, et al. 2012). In phase two of the study, various FASD prevention interventions, led by trained community health workers, were implemented

in the study sites over a one-year period. This included the distribution of pamphlets and posters that were designed in consultation with the local community (Chersich, et al. 2012). In addition, FASD related articles were regularly “published in local community newspapers and reinforced by regular advertisements on the local community radio. Local drama productions on FASD themes were performed” and “community workers presented health talks” on various topics “at clinics for infants and young children, family planning and antenatal care and at church and community meetings. Training workshops on FASD were held for provincial and district-level staff from the Departments of Health and Social Services. FASD prevention messages were mainstreamed within the Department of Health's activities and in their interactions with the public, with FASD topics given prominence in all National Health Promotion events” (Chersich, et al. 2012). Phase three of the study involved a follow-up assessment of FAS/PFAS prevalence 1 year after prevention activities were implemented. The same procedures were used as in phase one.

At baseline, prior to the implementation of the “prevention activities, education about harms of drinking during pregnancy was relatively low” (Chersich, et al. 2012). Only about half of the female participants knew “about the potential risks of drinking during pregnancy” (Chersich, et al. 2012). A little under 40% “recalled having received information about FASD on the radio or television, while about two-thirds reported receiving this information from a nurse” (Chersich, et al. 2012). FASD/PFAS prevalence was 8.9% (72/809) (Chersich, et al. 2012). Mothers of children with FAS/PFAS reported drinking on average 14.9 units a week during pregnancy (Chersich, et al. 2012). Post-intervention the average was 5.8 units a week and FAS/FASD prevalence dropped to 5.7% (43/71) (Chersich, et al. 2012). Changes in

the amount consumed were, however, only detected in mothers of children with PFAS, and not among women with a FAS child (Chersich, et al. 2012).

The intervention also “reached a large proportion of the population who recalled receiving information about FASD” – around 80% reported receiving information from nurses and about 60% reported that they received it from the media (Chersich, et al. 2012). Approximately three-quarters “of women believed that using posters to communicate information about drinking harms could modify women’s drinking” (Chersich, et al. 2012). Combined, “these findings provide supportive evidence of the need for enhanced community-level interventions in settings where levels of knowledge about the harms of maternal drinking are low” (Chersich, et al. 2012). But while universal approaches are better “suited to altering occasional episodic drinking in pregnancy, alcoholic women and those with depression require more individualized and specialized services to alter their drinking” (Chersich, et al. 2012).

9.5. Early diagnosis and intervention

Early diagnosis and being raised in a stable and nurturing home and receiving services for a range of physical, cognitive, psychological, sensory and speech impairments have been found to have a beneficial effect on children with FASD (Streissguth, et al. 2004; Zizzo, et al. 2013).

The “earlier identification of FASD is made the sooner intervention efforts can be implemented. A missed diagnosis has consequences, which accrue the longer the diagnosis is missed. Screening for and diagnosing FASD as early as possible after one year of age increases the possibilities that a child will receive appropriate care and stimulation to minimise developmental delays and that the mother will be supported so that she does not have another alcohol affected child” (Rendall-Mkosi, et al. 2008).

The testing for fatty acid ethyl ester (FAEE) in infant meconium (first stool) and scalp hair are two methods to screen for PAE and thus facilitate the early identification of children at risk for FASD (Zadunayski, et al. 2006; Zizzo, et al. 2013). In addition to enabling an early FASD diagnosis, testing the biological samples of infants can also “allow for counselling that could influence future maternal behaviour in subsequent pregnancies” (Zadunayski, et al. 2006).

However, despite the benefits of screening for biomarkers for PAE in the infant’s biological samples, testing raises ethical, social and legal concerns (Zizzo, et al. 2013). Zizzo and colleagues (2013:1451) explain that “Some are common to neonatal screening programs (e.g., parental consent, confidentiality, and third party disclosure), while others are related to the specific nature of FASD, where a positive result has implications for both the child and mother (e.g. both could be stigmatized)”.

In their reflection and commentary on the ethics of meconium screening for PAE, these authors identify “7 major ethical concerns in the ethical, social, and legal literature” (Zizzo, et al. 2013:1452). These relate to (i) the targeted populations for screening, (ii) consent to screening programmes and respect for persons, (iii) stigma and participation rates in screening programmes, (iv) cost-effectiveness of a PAE biomarker screen, (v) consequences of false-positive and false-negative test results, (vi) confidentiality and appropriate follow-up of positive screen results, and (vii) use of screen results for criminal prosecution (Zizzo, et al. 2013: 1452-1454).

According to Zizzo and co-authors (2013) “a key concern in the literature is the debate over whether or not screening tests should be offered to all pregnant women (i.e., universal screening) or limited to those deemed at risk (i.e., targeted screening). Both approaches are however fraught with problems. Although, “universal screening is most respectful of the principle of justice and minimizes the risk of stigmatizing

and stereotyping population groups viewed as at risk” (Zizzo, et al., 2013:1452), the approach gives rise to ethical questions concerning “cost-effectiveness, the use of limited healthcare resources, and the lack of distinction between apparently high-risk and low-risk populations” (Zizzo, et al., 2013:1452). On the other hand, although “targeted screening is viewed as a more economically viable option” concerns have been raised over its “potential for negative stereotyping, and for over identification of others” (Zizzo, et al. 2013:1452). One reason for being apprehensive about meconium testing is because “FAEEs have also been identified in meconium and hair samples from newborns of abstaining mothers” (Zadunayski, et al. 2006).

A particular problem concerning meconium testing for PAE is that is also a *de facto* test of the mother. And since medical testing or treatment of children usually requires the permission of the child’s parents or legal guardians, it is questionable whether women will consent to testing of their children when the test results will also reveal details about their drinking habits and when “the screen may engender negative legal and social consequences (e.g., stigma and removal of the child from the mother’s care) for both mother and child of the test results are positive (Zizzo, et al. 2013:1452). Therefore test results must be interpreted in ways that will not be harmful to women and particularly abstaining women (Zadunayski, et al. 2006). Although screening is beneficial, in that it can alert one to the need for diagnosis, it is not a substitute for a clinical diagnosis of FASD.

In addition to early identification and intervention, growing up in a stable and nurturing home has been found to be an important protective factor in ameliorating some of the secondary disabilities however this is not always the reality of a child with FASD in South Africa (Coons 2013; Streissguth, et al. 2004; 1994). For example in “five case studies in Gauteng, all of the children” with FASD “were either staying

with their grandparents or had been placed in foster care” (Rendall-Mkosi, et al. 2007). Whereas “five case studies in the rural Western Cape revealed that all of the children were still staying with their biological mother, even though some of the mothers continued to abuse alcohol and some had more than one alcohol affected child” (Rendall-Mkosi, et al. 2008). In another study in the Western Cape approximately “1 in 5 of mothers” of FASD children” were dead (Olivier, et al. 2013). Research-based interventions in the Western Cape have found “that in spite of cognitive and classroom behavioral difficulties, children with FASD from a vulnerable environment demonstrated significant cognitive improvements following a classroom intervention with a programme that targeted literacy and linguistic skills” (Rendall-Mkosi, et al. 2007). However a FASD diagnosis “often does not occur until school age, if at all, at which point maximal benefit from early intervention and support may not be achieved” (Zadunayski, et al. 2006).

10. Social and Economic Costs of Alcohol Abuse and FASD

Alcohol abuse and maternal drinking during pregnancy and consequently FASD has a significant impact economically, socially, and medically. When one considers the primary and secondary disabilities that result from prenatal alcohol exposure (PAE) – “intellectual deficits and learning disabilities; hyperactivity; attention and/or memory deficits; inability to manage anger; difficulties with problem solving; and prenatal and postnatal growth deficiencies - it is easy to understand that parenting a child with FASD presents a significant set of challenges throughout the life cycle of the child” (Rendall-Mkosi, et al. 2008). The birth of a disabled child, often places heavy demands on family morale, and if they are poor, thrusts them deeper into poverty and hence seriously hinders their development. Moreover, and depending on the nature

and severity of the child's disability, they would be unlikely to find meaningful employment and be almost entirely dependent on social assistance from the state.

Alcohol imposes a high economic cost on society (WHO 2004). A "conservative estimate of the economic costs of alcohol abuse (harmful use) based on research conducted in other countries is 1% of gross domestic product (GDP)" (Freeman & Parry 2006). Between 2000 and 2001, the harmful use of alcohol reportedly cost the South African economy approximately nine billion rand a year (Parry, Myers & Tiede 2003; Schmidt 2003). This amount includes the costs for alcohol-related crime, hospital expenses, and lost production (Parry, Myers & Tiede 2003; Schmidt 2003) and is almost twice as much as that which was received in excise duties over the same period (Freeman & Parry 2006). In 2009, alcohol was estimated to have cost the provincial and national health department R 6.1 billion and R 0.5 billion respectively (Budlender 2009).

The exact fiscal impact of FAS/FASD in South Africa is difficult to calculate, largely because no studies have been conducted to determine the national prevalence rate or the economic cost of FAS/FASD for the state. Where the issue of FAS/FASD has been considered, it has been considered under the general cost of alcohol abuse or birth defects and genetic disorders to the country. The cost of birth defects and genetic disorders to the country in terms of burden of disease is estimated to run into several million rand annually (Department of Health 2001). Cost estimates done in the US, have estimated the annual cost for FAS to range from US\$75 million in 1984 to approximately US\$4 billion in 1998 (Abel & Sokol 1991; Elliott, et al. 2008; Harwood, Fountain & Livermore 1998). Cost components include the types of costs

associated with FAS such as special⁸ medical and education costs and the costs of social services and support for disabled persons and their families. It is therefore likely that the cost of drinking during pregnancy and FASD to the state is grossly underestimated.

Although parents and families will, in many cases, cover the costs of caring for a child with FAS, this is not always the case, especially where the family is poor or dependent on social assistance from the state. In terms of the *Social Assistance Act* (No 13 of 2004), physically or mentally disabled adults and parents or caregivers of children with physical or mental disability may apply for social assistance, in the form of a cash payment or grant. If the person with a mental or physical disability is a child, i.e. legally, younger than 18 years of age, the child's parent, primary caregiver or court appointed foster parent can apply for a child dependency grant, if they are SA citizens or permanent residents who are living in the country. To qualify for the grant, the child must need full-time and special care. The applicant must submit a medical or assessment report confirming permanent severe disability. If the child's parent or caregiver has an income above a certain level they cannot get the grant. They do not qualify if they earn more than R144 000 per year if they are single, and if married, their combined income should not be above R288 000 per year. The income limit does not apply to foster parents. The care dependency grant covers disabled children from birth until they turn 18 (South African Social Security Agency 2011). As at April 2012, the grant amount was R1200 per month. Over a five year period (2005-2009) the number of children accessing care dependency grants rose from nearly 86 000 in 2005 to an estimated 109 000 in 2009 (South African Social Security Agency 2009).

⁸ Special costs are costs over and above ordinary costs and would include the (additional) costs for things such as medical treatment and social assistance

According to the 2012 Child Gauge (Hall, Woolard & Smith 2012), 117 246 children with severe disabilities currently receive the care dependency grant.

Disabled adults may qualify for a disability grant. To qualify for a disability grant, a person must be between 18 and 59 years if they are female or 18 and 60 years if they are male and they must not earn more than R47 400 if single or R94 800 if married. The person's assets must not be worth more than R792 000 if they are single or R1 584 000 if they are married. The applicant must either be a citizen, permanent resident or refugee and be living in the country and be unable to work because of a mental or physical disability. The applicant must undergo a medical examination where a doctor appointed by the state will assess the degree of disability (South African Social Security Agency 2010). As of 1 April 2013, the grant amounts to R 1260 per month. A person can get a permanent disability grant if their disability will continue for more than a year and a temporary disability grant if their disability will continue for a continuous period of not less than six months and not more than twelve months. A permanent disability grant does not mean that the person will receive the grant for life, but just that it will continue for longer than 12 months. The number of individuals receiving disability grants has more than doubled since 2000, rising to 1.4 million in 2008, and declining to 1.2 million recipients in 2010⁹ (South African Social Security Agency 2010). As at 2011, a total of 1,200,431 beneficiaries received disability grants, representing 8% of the total (South African Social Security Agency 2010).

A disabled adult who receives a disability grant, war veteran's grant or grant for older persons, and is unable to care for him or herself owing to physical or mental disability, may qualify for an additional grant called a grant-in-aid. As at January

⁹ The growth between 2000 and 2008 has been attributed to the expanding number of AIDS-sick people who were unable to access ARVs prior to the incremental roll out in 2004 (see Seekings & Nattrass 2005 and Nattrass 2006).

2013 the grant was R280 per month. To qualify for the grant-in-aid, the disabled person must provide a medical or assessment report, which shows they need full-time care (South African Social Security Agency 2010). A person does not however qualify for either of these grants if he or she is in prison or living in any kind of state-subsidized facilities such as an old age home or psychiatric hospital or is receiving care from a treatment centre (South African Social Security Agency 2010).

11. Concluding Remarks

Drinking during pregnancy predisposes one to adverse pregnancy outcomes. A child exposed to alcohol prenatally can suffer a range of disorders and disabilities in varying degrees. FAS is the most severe diagnosis on a continuum of disorders that can occur in a child exposed to alcohol prenatally. It is not a hereditary condition that can be passed onto one's children; it is the result of prenatal alcohol exposure through maternal drinking during pregnancy. Affected children experience physical and psychological impairment throughout their lives.

FASD is 100% avoidable if a woman does not drink during pregnancy. However a range of variables influence a woman's decision to drink, sometimes even during pregnancy and which places her at increased risk of having a FASD baby. Rather than focusing simply on alcohol use, "it is essential to understand" and intervene "in the accumulation of risk that puts an individual" at risk of having a FASD child (Coons 2013). Accurate data on drinking during pregnancy is crucial to the design and evaluation of prevention programmes that have some prospect of success.

Alcohol abuse and drinking during pregnancy are complex problems, inseparable from many other factors including a woman's mental health, her socio-economic status and family and community attitudes to drinking. Any programme that seeks to

make a positive change must understand and address the “array of interrelated demographic, social, economic, psychological and biological factors” (Rendall-Mkosi, et al. 2008), which not only influence a woman’s decision to drink but which “also increase or decrease the damage to the fetus for a given amount of alcohol” (Rendall-Mkosi, et al. 2008). Thus the success of prevention efforts requires that social conditions that contribute to the vulnerability of women to alcohol use also be addressed and that sufficient financial and human resources are provided to this end.

Concerning the range of risk factors for FAS/FASD, one may say that each one represents an important area of study that continues to further our knowledge of the effects of prenatal exposure to alcohol in children. However, irrespective of social, environmental, behavioural and genetic factors, absent maternal drinking, no child will be born with FAS/FASD. FAS and its lesser conditions are “100% preventable if a woman abstains from alcohol while she is pregnant” (Elliott, et al. 2008:183). But since a range of factors, in addition to maternal drinking during pregnancy, influence a woman’s drinking behaviour, it is logical that any programme that seeks to change drinking behaviours and reduce the potential harm that can occur in children as a result thereof, should have multiple targets and a variety of components (Andrews & Patterson 1995). We cannot expect women to simply abstain without taking account of the reasons they drink and may even do so during pregnancy. Thus the prevention of FASD cannot be left solely to women. For example women who abuse alcohol should have access to effective treatment and support that takes into account their specific reasons for drinking and the context within which they drink. Research has documented the variety of reasons why women may do so. Given this knowledge it seems absurd to expect all women to simply abstain. For one they must at least have information and an enabling environment. That means having access to effective

treatment and support, having decent living conditions and so on that gives them a chance at flourishing, or at least choosing and living differently. We know that knowledge is not enough, in order for people to effect the positive changes we expect them to, society must at least, enable them to not only make informed choices but also to obtain assistance in achieving these positive lifestyle changes. Health care-based interventions can be integrated with existing interventions e.g. TB and HIV programmes, thereby providing additional public health benefits and utilising limited resources more efficiently, but they must also be complimented with ones outside of health facilities.

Despite there not being a national prevalence established nor a precise calculation of FASD and its associated costs in South Africa, one can infer from the results of various localised studies that, it is potentially a much bigger problem that has serious implications for individuals and society. Estimates may be grossly underestimated for a number of reasons including that “prenatal surveillance for alcohol use is poor” (Rendall-Mkosi, et al. 2008) and the possibility of self under-reporting of alcohol use by women. “Because of the complexity and broad array of outcomes observed in individuals” with FASD, an interdisciplinary team that includes medical professionals, psychologists, occupational therapists and social workers –“is needed to assess and interpret accurately the broad array of outcomes that define” FASD (Astley 2011). In part poor surveillance, and consequently lack of accurate data, has to do with the shortage of trained medical professionals who can use validated screening and diagnostic tools (Burd 2006).

Medical professionals, as agents of the state, have an important role in reducing alcohol abuse. They can screen for alcohol use in their patients and provide accurate information about the risk of alcohol abuse and drinking during pregnancy in addition

to providing pharmacotherapy and referring them to treatment and other support services (WHO 2010).

Early identification of children at risk may lead to early diagnosis and consequently early participation in developmental interventions, which, in turn, improve the quality of life for FASD children, including the prevention of future mental health problems. A medical diagnosis serves several purposes including facilitating communication between medical professions and patients in health care teams and assisting in the study and treatment of FASD (IOM 1996). But while these interventions may appear to have a good cost-effectiveness profile they are not without ethical problems. For example, they can be implemented in ways that are potentially discriminatory and stigmatising.

While women in all socio-economic groups and areas use alcohol, certain groups, e.g. women labelled “high risk” or residing in “high risk communities”, may be unfairly targeted and subject to more invasion of their privacy, thus likely to experience adverse outcomes from screening and diagnosis. Placing an individual in a diagnostic category confers both benefits and disabilities. For example, a FAS diagnosis may validate an individual’s disability and facilitate appropriate interventions and social benefits. On the other hand, the diagnosis may also be used to stigmatise the affected individual, his or her mother and family (IOM 1996).

FASD is not restricted to the children in rural and agricultural communities - it is a problem in urban communities as well. Any woman of any socio-economic or cultural group who drinks during pregnancy can have a child with FASD, but poor women are at greater risk for having a FASD child (Armstrong & Abel 2000). However those women who are better off financially and educated and who drink socially are equally at risk of having a child with FASD (Coon 2013).

FAS is a huge problem in some parts of South Africa - notably in agrarian communities. Although much of the “investigation into the historical influences that have shaped drinking patterns” in the country have focused largely on the dop system (McKinstry 2005; London 2000; 1999; Parry & Bennetts 1998; Te WaterNaude, et al. 1998), “it is erroneous to associate” it only with “wine farms and wine-growing regions of the Western Cape” (Rendall-Mkosi, et al. 2008), where high rates of drinking and problem drinking have been observed among “both male and female farm workers” (Rendall-Mkosi, et al. 2008). The system was also widely used to secure and control labour in the “deciduous fruit industry” (Rendall-Mkosi, et al. 2008) and in the mining industry (Mager 2004; Parry & Bennetts 1998) in other communities in the country. This is extremely important for FAS prevention “efforts as there are likely many high prevalence areas, which have been subject to similar social, cultural and economic forces as the wine-growing areas” (Rendall-Mkosi, et al. 2008) of the Western Cape and thus explain the equally high rates of drinking among pregnant women and FAS that have been observed in communities elsewhere, notably the Northern Cape (Urban, et al. 2015; 2008; Viljoen, et al. 2003) and Gauteng (Ojo, et al. 2010).

There are a few validated screening and diagnostic tools available, however, in the absence of objective accurate and reproducible methods for assessing and the severity of exposures and outcomes in individual children, diagnoses are likely to vary widely among professionals and health establishments (Aase, Jones & Clarren 1995; Astley 2011; Astley 2006). “From a clinical perspective, diagnostic misclassification leads to inappropriate patient care, increased risk for secondary disabilities and missed opportunities for primary prevention. From a public health perspective, diagnostic misclassification leads to inaccurate estimates of incidence and prevalence. Inaccurate

estimates frustrate efforts to allocate sufficient social, educational and health care services to” the populations at “risk, and preclude accurate assessment of primary prevention efforts” (Astley & Clarren 2000).

While there remains some uncertainty as to the exact amount of alcohol that is damaging to the fetus and consequently child, heavy maternal drinking during pregnancy is an established risk factor for FAS. This does not however exclude the possibility “that even low levels of alcohol” may place the child “at risk of permanent, neuropsychological impairment later in life” (Rendall-Mkosi, et al. 2008). The fact that light or moderate drinking has not been found to affect very young children, does not exclude the possibility of developmental problems emerging later in childhood. Because it remains unclear what the level for drinking safely during pregnancy is and how this level might be affected by individual susceptibility, no amount of alcohol can be guaranteed to be safe (Day 1992; Goodlett & Petersen 1995; Nathanson 2007; Streissguth et al. 1994). The safest and prudent option for women to avoid FAS thus remains avoidance of alcohol during pregnancy.

Because alcohol can damage the fetus at any point in its development, although to differing degrees, all sexually active women of reproductive age who do not wish to be pregnant and give birth to an alcohol-affected baby should avoid pregnancy by using effective contraception or where they have a right to an abortion, consider terminating their pregnancies.¹⁰

¹⁰ See Chapter 4 for an elaboration of the conditions under which women in South Africa may lawfully terminate a pregnancy.

Chapter 3: Moral Responsibility

1. Introduction

In this chapter I consider different accounts of responsibility and distinguish these from the notion of moral responsibility. I discuss two important criteria expressed by Aristotle as pre-conditions for the proper ascription of moral responsibility (understood here primarily in terms of blame instead of also praise). By Aristotle's account moral agents can be held morally responsible for their voluntary actions. However, not everyone agrees that we have free will, i.e. that our choices and actions are voluntary. This has important implications for moral responsibility. If people don't have free will, in other words, if events are predetermined on what basis can we hold them morally responsible? I argue that, even though we may not be fully in control of our actions because of the limited options available to us, we can and should recognize the notion of moral responsibility, even if only for utilitarian reasons. I conclude with a discussion of factors that diminish and excuse one from full moral responsibility.

2. Moral Responsibility

When we use the term responsibility we often use it in different ways to mean different things. Sometimes we use it in a sense that assigns causal responsibility to something, i.e. identify a cause, causal factor or reason for a particular outcome, event or state of affairs. Other times we use the term responsibility in the sense that involves evaluations of a person's character - whether they are responsible or irresponsible.

Often too, we use the term responsibility in a sense that denotes blame (or praise, as the case may be) when someone fulfils or fails in fulfilling their duties and we hold her or him accountable.

2.1. Moral Responsibility and Causal Responsibility

Moral responsibility is related to, yet distinct from both causal and legal responsibility. Assigning causal responsibility involves identifying a causal connection between an earlier occurrence (X) and a particular event, outcome or state of affairs (Y). Causal responsibility applies to persons, objects, happenings, failings to happen, actions and omissions. We assign causal responsibility when we say things like ‘The heavy rainfall is responsible for the flooding in the area’ or ‘Alcohol abuse is responsible for many deaths and injuries’ or ‘The cat is responsible for the glass of milk falling from the chair.’

But while anything, not only persons, can be found to be causally responsible i.e. cause an outcome to occur, only persons can be morally responsible for something and thus have moral responsibility. What this means is that they are answerable for or can be called upon to account for it, to explain, to justify or admit responsibility for it - and can be held accountable for their dispositional traits, their choices, conduct and its consequences (Duff 1998).

Usually if someone is causally responsible for something they are also morally responsible for it, for example someone who kills an innocent person, is not only causally responsible but usually also morally responsible for bringing about this person’s death. However this is not always the case. For example although a child may have caused a harmful state of affairs to occur as a result of its action, we tend to not hold them fully morally responsible as we would and do normal adults for the

simple reason that we do not tend to think that children have full decision making capacity.

Because moral responsibility involves making moral judgments or evaluations of a person's decisions, actions, the results of their actions, or their dispositional traits, it falls within the domain of morality and is necessarily concerned with what philosophers refer to as an individual's prospective and retrospective responsibility and their attitudes towards their responsibilities (Eshleman 2014; Klein 1995; Williams 2009).

2.2. Moral Responsibility and Legal Responsibility

As is the case with causal responsibility, legal responsibility is also related to yet distinct from moral responsibility. Our judgments about legal responsibility are based on the laws of the particular land, where "legal institutions assign responsibilities to people, and hold them responsible for failing to fulfil these responsibilities – either via the criminal law and policing, or by allowing other parties to bring them to court via the civil law" e.g. breach of contract (Williams 2009). In liberal societies, there is usually convergence between moral and legal responsibility. Usually the law will uphold important moral principles.¹¹ Examples of where law and morality clearly overlap are the crimes of murder and theft. Few, if anyone, would deny that "it is both a legal and moral wrong" to intentionally kill an innocent person or to take another's property without permission (Williams 2009).

However, while legal and moral responsibility often overlaps, they do sometimes diverge. For example, we may find it immoral for someone to break their promise or to commit adultery, but we do not tend to think that all instances of promise-breaking

¹¹ Arguably, in corrupt, tyrannical states, legal and moral responsibility would typically have no relation at all (Williams 2009).

or that adultery should be punishable offences. Moreover, while the law may legitimize certain conduct e.g. abortion, euthanasia or same sex marriage, this does not mean that such conduct is necessarily moral. Even in places where these practises are legal, they remain the subject of intense debate.

Moreover it does not necessarily follow that because something is morally required or permitted that it should be legally sanctioned or proscribed i.e. that someone should be penalized or held accountable in the court system for an event that has occurred or for failing to fulfil what is considered to be their moral responsibilities. There may be compelling moral reasons to not always make moral responsibility a legal responsibility.

And while both law and morality are concerned with intentions and outcomes, law “does not prioritize intentions over outcomes in the same way that many believe that moral” judgments should (Williams 2009). For example, law does not punish an attempted crime e.g. “attempted murder in the same way as an actual murder” (Williams 2009). The “difference between murder and” attempted murder “may not lie in the intention or even in the actual” injuries inflicted: “everything depends on the outcome”, i.e. “whether death results. Thus, the crimes attract different punishments, though our moral judgment of someone may be no lighter in the case” (Williams 2009) of attempted murder. Moral responsibility is concerned with an individual’s prospective and retrospective responsibility, i.e. with an individual’s duties and what an individual can rightly be held accountable (blamed or praised) for.

2.3. Prospective Responsibility (Responsibility as Duty)

Prospective responsibilities are “those matters that it is up to me to attend to or to take care of” (Williams 2009). When we are concerned with a person’s responsibilities in

this forward looking sense, we are concerned with what he or she ought to be doing or attending to, in other words, their duties. Robert Frazier (1998) explains that having a duty to do something is “like having been given a command by someone who has a right to be obeyed: it must be done“. Therefore when we say someone has a duty we mean that he or she is subjected “to a binding normative requirement and unless there are reasons” to do otherwise, he or she “is required” to “satisfy it and can be justifiably criticized for not doing so” (Craig 1998). An important feature of the concept of duty is that it provides a justification for our action. Explaining why we did something by saying we had a duty, i.e. that we were obliged to (not) perform it, is offering a defensible reason, i.e. a justification, for (not) doing it (Lenman 2009).

2.3.1. Duty and other normative concepts

The concept of duty is related to various other important philosophical concepts, including the concepts of permission, prohibition and rights. The connection between permission, prohibition and duty is relatively “straightforward: if we are permitted to do something, then we do not have a duty not to do it; if we are prohibited from doing something, we have a duty not to do it” (Frazier 1998).

The relationship between duties and rights is however not as obvious. One important view of the relationship between duties and rights holds that “there is a correlation between, at least some rights and duties” (Frazier 1998). WD Ross (1930:48), for example, argues that (i) “A right of A against B implies a duty of A to B” and (ii) “A duty of B to A implies a right of A against B”. Essentially what Ross proposes is this: If you have a right against someone, they have a duty toward you, and if you have a duty to another, they have a right against you. For every right a person has, someone else has a duty. So, for example, if you borrowed money from a friend with the

promise to repay it, your friend has a right against you and you have a duty (grounded in the duty of promise keeping) to repay your friend. Similarly, someone's right to not be harmed posits a concomitant duty on others to not harm them (at least not without a valid defence).

One problem with the view - that there is a general association "between rights and duties, where right implies duty and duty implies a right" (Duff 1998) - is that it compels us to grapple with questions about the sorts of entities that can have duties and rights and against whom there can be rights, where a right can simply be defined as justified claim.¹² For example, can fetuses, animals and the environment have rights and duties? This question has important implications. If, for example, fetuses are the sorts of beings that have rights, then others are obliged to respect their rights, i.e. others, including pregnant women, have duties to it. However, if they are not the sorts of beings that have rights, it seems that others do not have duties to it. But we tend to think that one can have duties to something, even if that thing does not have rights, so in an effort to address this problem, another view of the relationship between duties and rights holds that while being a person or having moral agency is a necessary condition for being the bearer of duties, it is not a necessary condition for being the object of duties of others. This view therefore recognises that one may have duties to an entity even though that entity does not have rights. In other words, that one may have duties towards another being even if that being does not have a concomitant right to have it fulfilled.

¹² By contrast, a privilege is ordinarily understood to be something that we may be offered or have taken away from us.

2.3.2. Types of duties

A number of distinctions have been offered between different types or kinds of duty (Frazier 1998). The most important distinctions include those between positive and negative duties, those between *prima facie* and “all things considered” duties and the distinction between duties and obligations.

2.3.2.1. Positive and negative duties

Often a distinction is made between positive duties of beneficence and negative duties grounded in the principle of non-maleficence. Underlying the distinction between positive and negative duties is the more fundamental and contentious claim that there is a morally significant difference between acting (i.e. taking positive steps) and refraining from acting (i.e. doing nothing or omitting to act). The general idea is that positive duties concern what we are required to do e.g. help those in need and care for others, while negative duties concern what we are required to refrain from doing e.g. not to kill or wrongly injure someone. The implication of the distinction between positive and negative duties is this: if we believe that morality consists largely or exclusively of constraints on our action, i.e. mostly negative duties, then we may believe them to be more stringent or important than the positive ones. Indeed, it is sometimes held that there can be a duty not to bring about something, while there is no duty to prevent it from occurring. For example, we may believe that we have a duty not to drown another person, but at the same time, believe that we do not have a duty to save them if they are in the process of drowning. Equally, in medicine, while physicians are not allowed to kill their patients, they are not obliged to make futile attempts to save a patient’s life. So while we may have a duty to not harm or to kill others, it is debatable whether we have a duty to rescue or save them from harm.

If, however, one is more inclined to consequentialism and believes that outcomes are what matters in the moral evaluation of our actions, then the claim that there is sometimes a morally significant distinction between an act and an omission is somewhat problematic. This is because consequentialists, even if they do recognise a distinction, do not generally consider it to underpin a morally relevant difference between positive and negative duties. Consequentialism, as an approach, is concerned with promoting values (rather than with motives for action or adherence to duties), and it does not matter whether acting or refraining from acting is promoting those values. What matters are the consequences of our actions or failure to act (omissions), so by consequentialist standards it doesn't really matter whether or not one had a duty to act in a particular way, what matters are the consequences of our decisions and actions - be it to act or to not act.

2.3.2.2. Prima facie and 'all things considered duties'

WD Ross (1930) offers another important distinction between kinds of duties, i.e. what he calls *prima facie* duties and "all things considered" duties. Contrary to its literal meaning, a *prima facie* duty is not one that merely appears to be a duty. It is a conditional moral duty that can be morally outweighed, or overridden by other moral considerations. It is one that does not overwhelm other considerations in all circumstances (Murray 1991; Steinbock 2001). So, it is a duty we ought to fulfill if there is not a more important moral duty to override it. For example, assume that a person can choose between telling the truth and protecting someone from harm, but cannot do both. Telling the truth and protecting someone from harm are both *prima facie* duties. By contrast, an "all things considered" duty is what duty requires, all things considered, in particular, given all the *prima facie* duties.

2.3.2.3. Duty and obligation

Some philosophers e.g. WD Ross (1930) make a distinction between the concepts of “duty” and “obligation”. They restrict their use of the term “duty” to refer only to those “moral requirements” that “apply to all” people “irrespective of status or acts performed and which are owed by all persons to all” other persons (Simmons 1979). Duty is thus used to refer only to our non-voluntarily assumed responsibilities, i.e. our *natural duties* or those that we have *vis-à-vis* everyone else, simply in virtue of our being human. By contrast, the term “obligation” is restricted to those (special) responsibilities or duties, which individuals owe to only some limited class of persons, and which consequently justify us giving preferential treatment to them.

Unlike the concept of duty, which is justified by the intrinsic nature of persons, the basic or fundamental justification for recognizing the concept of obligation has to do with the special relationships that exist among people. We stand in a special relationship to those with whom we voluntarily enter into contract or to “whom we have made promises or commitments of some sort” (Jeske 2008). Obligations therefore include those duties that we freely choose to take on but also those duties that derive from our social roles or status in society, even when these positions are neither voluntarily nor explicitly chosen by a person (Hardimon 1994; Jeske 2008; Manning 2001). What we may call role responsibilities are also special obligations. Role responsibility involves the duties one has for doing various things which come with occupying a certain role in society, whether those social roles have been voluntarily assumed by us or delegated or given to us.

Although the idea of obligations and special relationships seems counterintuitive to utilitarianism and modern thinking about human equality, which urges us to be

impartial¹³ when weighing the interests of different people, the idea is widely accepted in common morality that places value on personal relationships and expects us to treat intimates in partial (or preferential) ways. The idea can, however, be defended on consequentialist grounds. A consequentialist can argue that there is instrumental value in recognizing the concepts of obligation and special relationships because each person acting so as to benefit her children, family, friends, promises and so forth will have the best overall consequences. John Stuart Mill (1863) notes “that few hurts which human beings can sustain are greater, and none wound more, than when that on which they habitually and with full assurance relied fails them in the hour of need” (Mill 1863, Ch. 5). What Mill is suggesting is that we have certain natural affections and expect others to act on them. When they don’t act in accord with these expectations, pain is caused by deviations from them.

Setting aside the philosophical debate about the concepts of duty and obligation, I will use the terms duty and obligation interchangeably since little, if anything, of moral significance seems to ride on my choice of terminology. By duty I will therefore mean one’s natural duties and one’s obligations, whether acquired voluntarily or derived as a consequence of one’s social and professional role in society.

2.4. Retrospective Responsibility (Responsibility as Blame)

Retrospective responsibility is related to prospective responsibility, in that it involves making a moral judgment or evaluation of a person’s (past) actions or the consequences of their actions or their attitude to their duties. According to Williams (2009), this “judgment typically pictures the person as liable to various consequences: to feeling remorse (or pride), to being blamed (or praised), to making amends (or

¹³ The utilitarian idea of impartiality can be found in Jeremy Bentham’s well-known expression, that “Each to count for one and none for more than one”.

receiving gratitude) and so forth.” Retrospective responsibility therefore involves the assignment of praise, desert (fairness or just reward) or blame (the assignment of fault) for what someone has done or failed to do, in discharging his or her duties (Duff 1998).

People who fulfil or act in accord with their duties and have “caused some good state of affairs” to occur are typically praised for acting in responsible ways ((Schoeman 1980). Conversely one is usually blamed for having caused a harmful state of affairs to occur, for failing to act in accord with one’s duties, for acting in irresponsible ways and for assuming or lacking certain character dispositions.

If someone fails to perform his or her duties, we tend to hold them responsible in a retrospective sense. Our retrospective responsibility is therefore partly determined by our prospective responsibilities. So, if we are to determine the scope of a person’s retrospective responsibility, we must first determine the nature and scope of his or her prospective responsibilities, in other words what their duties are.

However, when we are concerned with moral responsibility, we are also concerned with a person’s attitude to their duties. Thus we may (and often do) describe people as being responsible or irresponsible, where being a responsible person is someone who “can be relied on to judge and to act in certain morally desirable ways” and “be counted on to take her responsibility seriously” (Williams 2009). Conversely, “the irresponsible” person “is not one who lacks prospective responsibilities, nor one who may not be held responsible retrospectively. It is that she does not take seriously her responsibilities” (Williams 2009). So, moral responsibility is also concerned not only with duty, but also with virtue that people “exhibit in one area or perhaps exemplify in their entire lives” (Williams 2009).

The scope of our retrospective responsibility is controversial. We are responsible for our voluntary actions and the intended and foreseen “results of our actions, but how far we are responsible for their foreseen effects, or for harms that we do not prevent when we could, depends on how we should define our prospective responsibilities, that is, on how far we should regard such foreseen effects, or such preventable harms, as our business” (Duff 1998). To say that someone is responsible for some foreseen effect, or for a harm which they did not prevent, is to say that they have a duty; that they should have attended to that effect or to that harm in deciding how to act. But while the nature and scope of our duties of non-interference is relatively uncontroversial, the nature and scope of our positive duties is less clear.

Concerning our attitudes to our duties, if we take vicious or wicked attitudes or intentions as the standard for moral responsibility the degrees of responsibility will vary with the wickedness of the person’s character, attitudes or intentions. Because consequences don’t matter, a person who makes a failed attempt to harm another person would be as responsible as a person who succeeded in doing this. If we take actually causing harm to be the standard of responsibility, then likewise, the degrees of responsibility will vary with the degrees of the overall harmfulness of the actual consequence. There are however two problems with this standard of responsibility. Firstly, according to this standard, it neglects a person’s knowledge and intentions. Hence, someone who accidentally caused harm would be as responsible as a person who expected or even intended to cause harm. The second problem – that of attempts - is related to the first. The standard implies that a person who made failed attempts to harm another could not be responsible. If we take actual performance of a wrong action to be the standard of responsibility, we are, similarly, faced with problems. Like the other standards, the degrees of responsibility will vary with the degrees of the

wrongness of the action. Moreover, a person who unknowingly or unintentionally took a wrong action would be as responsible as a person who knowingly and intentionally took the wrong action.

3. Who Can Have Moral Responsibility For What?

Aristotle (2009) is credited as being the first philosopher, in the Western philosophical tradition, to explicitly construct a theory of moral responsibility in *Nicomachean Ethics* (Eshleman 2014). According to him moral agents are responsible for their voluntary actions (Aristotle 2009, Bk 3). He specifies two essential conditions that are required for the proper ascription of moral responsibility, viz. the freedom (control) condition and the mental (cognitive capacity) condition (Eshleman 2014). To properly ascribe moral responsibility to a moral agent, the agent must have the requisite decision making capacity and the action or decision must have been made freely (voluntarily). This means that it must have been possible for the agent to perform it and been made free of coercion and compulsion and based on an appraisal of all the relevant information. Joel Feinberg (1971) explains that, “one assumes risk in a fully voluntary way when one shoulders it while informed of all relevant facts and contingencies and in the absence of all coercive pressure or compulsion” (Feinberg 1971:105). Thus, to be a free action the action must be the outcome of a free and deliberate choice by a moral agent. If the choice or action is not one’s own, it is not freely made because one did not have complete control of it, in the sense required for moral responsibility.

3.1. Who is a moral agent?

Moral agents can have moral responsibility and be held morally responsible. A moral agent possess certain psychological capacities of understanding and reasoning that enable the agent to reflect on a situation, to form intentions about how he or she will act, to evaluate reasons and give an account of his or her actions (Williams 2009). A moral agent is therefore capable of reasoning and acting on the basis of reason. Moral agents are not restricted to acting on the basis of instinct, desire or emotion. Normal adult persons represent our paradigm case of moral agents. They can have rights and duties and be held responsible for their decisions, actions and dispositional traits. In both Kantian and non-Kantian philosophical traditions, only persons can have moral responsibility, i.e. have duties and be held morally responsible for their actions, omissions and character dispositions

3.1.1. Individual and collective responsibility

Although moral responsibility is typically ascribed to individuals, it can also be applied to collectives. Moral responsibility as it pertains to individual moral agents is often referred to as personal or individual responsibility. This is to distinguish it from accounts of what is called collective responsibility. Unlike personal responsibility, collective responsibility construes groups as moral agents and associates both causation and blameworthiness (fault) with collectives or groups, as opposed to specific individuals and their actions (Smiley 2010; Risser 2009).

There is an extensive debate in moral philosophy about whether collectives such as a state, a community, a corporation or other organization can have moral responsibility, in other words, can have moral obligations and be held accountable in the same way that individuals can. A number of authors, for example, Erskine (2010), Wringer

(2010) and Miller (2004) have however argued in favour of considering collectives to be moral agents and thus as potential holders of moral obligations (Schwenkenbecher 2011).

Toni Erskine explains that “a collectivity is a candidate for moral agency if it has the following: an identity that is more than the sum of the identities of its constitutive parts and, therefore, does not rely on a determinate membership; a decision-making structure; an identity over time; and a conception of itself as a unit” (Erskine 2010:72). Erskine calls collectives that have these features “institutional moral agents” (Erskine 2010:72), who can have prospective and retrospective responsibility. Moral obligations ascribed to states cannot however be independent of moral obligations of the individuals represented by the collective or the individuals consisting of the collective. To claim that a collective’s obligations are the obligations of the collective itself rather than an obligation of its members would be to generate “a somewhat artificial distinction between a collective and its members. If a collective could hold moral duties in a way that results in no moral duties for its individual members, this would leave us with no one to hold accountable and with no agent who could feel morally motivated to put things right” (Schwenkenbecher (2011:83).

Anne Schwenkenbecher (2011:89) explains that “moral duties held by a collective - for example a state - entail duties for individual members of that collective, both occupants of institutional roles (such as politicians) and persons with no institutional role”. She calls “these entailed duties contributory duties” and holds that they “entail professional duties” (Schwenkenbecher (2011:89).

According to Schwenkenbecher (2011:88), a collective “can only hold moral duties because it is capable of collective action, i.e. more than just aggregate actions and because it consists of individual members who hold corresponding individual duties”.

However, these duties differ depending on the individuals' positions within the collective.

Schwenkenbecher (2011:89-90) proposes three criteria to determine the extent “of an individual agent or sub-group’s contributory duty to a collective duty”. The first criterion that determines how much an individual within a collective must contribute to the collective duty is the agent’s capacity (Schwenkenbecher (2011:89-90).

Schwenkenbecher (2011) explains that individuals with greater power to discharge a collective duty have a greater contributory duty, because they are more capable or better placed to discharge it. “This criterion clearly establishes stronger contributory duties for those members of a collective who hold an institutional role” (Schwenkenbecher 2011).

The second criterion that Schwenkenbecher says determines the extent of individual contributory duties is what she calls ‘moral correlation of the agent to the problem that the collective duty aims to address’ (Schwenkenbecher 2011). This means that “individuals (or sub-collectives) that have responsibility for the occurrence of the problem have to contribute more to solving the overall problem than others, other things being equal” (Schwenkenbecher 2011).

Finally, “how much an agent or sub-group has to contribute depends on how much the other agents contribute and how much the agent has publicly committed herself to contribute. If I have made it clear to other members of the collective that I will take on a particular contributory task in the context of discharging a collective duty, I have a stronger obligation to do so than if I had not announced this, because I make others believe that they need not undertake this contributory task. It is also now more likely not to be undertaken at all, should I not do it” (Schwenkenbecher 2011).

Two of the criteria proposed by Schwenkenbecher to determine the “magnitude of an individual agent or sub-group’s contributory obligations – capacity and commitment – indicate that those who are in a position of power within a state, usually politicians, above all the government, but also other influential figures of public life, have the strongest duties to contribute to discharging the moral duty of the state. Hence individuals who fail to discharge their contributory duties in an obvious way—for example politicians who ignore the problem of climate change or even deny it—are morally liable to punishment as individuals. But the second criterion—*moral correlation*—suggests that persons with limited power and with no explicit (professional) commitment, who are in some way responsible or benefit from the problem the duty addresses, have contributory duties as well” (Schwenkenbecher 2011).

3.2. When is an action voluntary?

To have moral responsibility an agent must have the requisite decision-making capacity (cognitive capacity or competence) and to be morally responsible the actions they perform must be voluntary. Typically, an action is voluntary if it is within the agent’s control. Aristotle recognizes that there are events that are out of a person’s control. For example, events such as death and ageing are part of natural occurring processes over which we have no control. They cannot be altered by our desires, our decisions or beliefs. For Aristotle, we have control when things are up to us. Things that are up to us, hence over which we have control, are those things that are not caused by nature, necessity or fortune, but by our own minds (Aristotle 2009: 1112a31). Having control over one’s actions and choices in this way requires that one is able to choose from an array of alternative possibilities, and that the source of one’s

choices and actions is oneself and not in anything or anyone over which one has no control (Kane 2002). An action is therefore voluntary if one is able both to perform and to not perform it, i.e. if it is up to a person whether (or not) to perform it.

4. The Problem of Free Will for Moral Responsibility

As humans we tend to value our freedom and autonomy. Intuitively we believe that we have free will and control; that we can choose if, where, when and how to execute our choices. Free will is an important issue in discussions on moral responsibility, because one's conception of free will defines one's views on moral responsibility.

Determinism negates the idea that we have free will, consequently freedom of choice and action. Causal "determinism is the idea that every event is necessitated by antecedent events and conditions together with the laws of nature" (Hoefer 2010).

Determinism is thus the view that views people as not having free will because everything is caused by prior events. If determinism is true, then it is impossible for anything else to happen; people's will, choice or action makes no difference to what will happen. Because the deterministic view holds that fate determines everything and that our destinies are predetermined, it implies that we do not have freedom (of choice and action), at least in the sense required for moral responsibility and consequently cannot be responsible for our behaviour. Arguments in support of moral responsibility fall into two groups that differ according to whether they regard free will as compatible with determinism.

4.1. Compatibilism

Common to all compatibilist accounts of free will is that they reject the suggestion that determinism is the relevant concern. Compatibilists as the name suggests think

that determinism is compatible with free will provided that certain minimal conditions of voluntariness are met (Bishop 2010). Different compatibilists define free will differently and provide differing reasons for the idea that we have free will. Additionally, they take different kinds of constraints to be relevant to the issue of moral responsibility.

Classical compatibilists such as David Hume for example defines free will as a lack of physical restraint when he asserts that “liberty is universally allowed to everyone who is not a prisoner and in chains” (Hume 1967, Ch. 8). Similarly in *Freedom of the Will*, the 18th century preacher, Jonathan Edwards argues that even if we do not *will* as we will (that is, do not choose what we will to do), we *do* as we will” (Edwards 2009).

“Modern compatibilists make a distinction between freedom of will and freedom of action” (O’Connor 2010), i.e. they separate “freedom of choice from the freedom to enact it” (O’Connor 2010). Philosophers who distinguish between free will (choice) and freedom of action “do so because our success in carrying out our ends depends in part on factors wholly beyond our control” (O’Connor 2010). Having free will, understood as being capable of making a free choice, does not therefore imply freedom of action because “there are always external constraints on the range of options that we can meaningfully try to undertake” (O’Connor 2010).

For some compatibilists, “the central loci of our responsibility are our choices, or “willings” (O’Connor 2010), rather than our actions. Daniel Dennett (2003) for example argues that free will can exist “because individuals have the ability to act differently from what anyone expects” (O’Connor 2012). His “basic reasoning is that, if one excludes God or other such possibilities, then because of chaos and epistemic limits on the precision of our knowledge of the current state of the world, the future is ill-defined for all finite beings” (O’Connor 2010). He argues that “the only well-

defined things are expectations” and that “the ability to do otherwise only makes sense when dealing with these expectations and not with some unknown future” (O’Connor 2010). So even if causal determinism is true, we can still choose how we act.

Other compatibilists include our character or attitudes as the forces that determine what we *will* do and what we *do*. Robert Cummins (1980) for example argues that “if character is the dominant causal factor in determining one’s choices, and one’s choices are morally wrong, then one should be held accountable for those choices, regardless of genes and other factors (Cummins 1980).¹⁴ Because we can choose our character dispositions, e.g. choose to be honest and kind as opposed to being wicked and cruel, we can therefore mostly be held morally responsible for our character dispositions, in other words, we can normally justifiably be criticized for it. For example, even though a paedophile may believe that he has no choice than to abuse children, he can still be held responsible, because we tend to think it is right to hold responsible those with bad character. In simple terms, what matters is not how one comes to possess a particular attitude, but that one has it and acts on it.

4.2. Incompatibilism

Incompatibilists “define free will as freedom from determinism” (O’Connor 2010). Incompatibilists think that determinism and free will are incompatible. They argue that if a person’s actions are determined by prior events or past actions, then such actions are not freely chosen. For them the “major question regarding whether or not

¹⁴Some people suggest that all our actions are caused by our circumstances, including our genes and our upbringing. The implication of this view is that we can’t and don’t choose anything. And if we have no choice, we can’t be morally responsible for anything. But even if people may not be able to have done otherwise, it does not mean that they didn’t make a choice to act as they did.

people have free will is whether or not their actions are determined” (O’Connor 2010).

Some incompatibilists conclude that our actions are in fact predetermined and they are therefore reluctant to assign moral responsibility, whereas others reject determinism in favour of the view that we freely choose our actions. For them, so long as we freely choose our actions we are morally responsible for them and can therefore be held morally responsible.

Indeed “if causal determinism were true about human actions across the board, we would not have free will” (O’Connor 2010). If everything is predetermined, our past and our future, our fate is somehow destined, then in what sense and to what extent can we be said to be responsible for something over which we have no control?. If we can cause nothing to (not) occur, in other words, if we have no choice or control over whatever happens, how can we be held responsible for anything? To deny that people have free will therefore has serious implications for moral responsibility. This is arguably why Jean-Paul Sartre asserts that determinism enables people to sometimes avoid responsibility, when he says that, “we are always ready to take refuge in belief in determinism if this freedom weighs upon us or if we need an excuse” (Sartre 2012[1943]).

Even though the incompatibilist argument against free will is compelling, there are several reasons why we should recognize that people have free will and consequently moral responsibility. Firstly, we can’t not believe in free will, because our experience is that we do not merely do as we will, we also will what we will. We tend to think that we can and more often do choose our actions and attitudes; that we can choose what we will do and act on the basis of that choice. If we deny the possibility of free will, the implication is that no one can be held responsible for anything. We can

imagine a world in which everyone has internalised a habit of excusing others. In a world of this sort, we will excuse everyone for anything and everything because nothing is their fault, they cannot help but do what they do. But we tend to think that people have choice – that their actions can be the product of conscious deliberation, of mulling over alternatives and weighing options. Another reason for recognizing that we have free will (even in a deterministic world) is quite simply because it is an essential tool to control antisocial behaviour. Unlike the first reason, this justification does not rest on whether or not someone deserves to be held responsible, but rather on the social benefits that come with holding people responsible. “When people act together, forming a collective agent, holding one another *accountable* is an essential part of that collective agent’s way of guiding its movements. It is the way we collectively mind what we are collectively doing. When we fail as a result of one of us not minding what he is doing, something has to be settled about what has happened before we can decide to go on acting together, or to give it up. It is in this context that we blame each other for faulty action” (Korsgaard 2013).

A commitment to morality thus requires the recognition of responsibility for violating rules we have made collectively as a society. One could plausibly also maintain that holding others responsible is a way to show respect for them. One could argue that when we hold someone responsible we respect that person’s “fundamental human right to be treated as a person by permitting him or her to make the choices that will determine what happens to him” (Korsgaard 2013) or her and holding them responsible for their actions. Thomas Scanlon (2008; 1998) for example argues that “refusing to blame others... involves an attitude of superiority toward the person in question (something like the attitude of a parent toward very young child) and thus

represents a failure to take that person seriously as a participant in the relationship.” A final reason for recognizing free will and consequently moral responsibility is straightforwardly because it’s what we do. Even though we may think that we do not have a right to judge, or that we are morally obligated to do so, we do it anyway. “There are no metaphysical facts of the matter about whether people are responsible for what they do. Instead, holding people responsible is a practice—it’s something that we *do*” (Korsgaard 2013). Perhaps it is because we think it motivates decent behaviour, which makes the world better off as a result.

5. Factors that Diminish and Excuse One from Moral Responsibility

Feinberg (1971) explains that one’s choice or action is completely involuntary (i.e. not one’s own) when “it is no choice at all”, as “when one lacks all muscular control over one’s movements, or is knocked down or sent reeling by a blow or an explosion – or when, through ignorance, one chooses something other than what one means to choose, as when one thinks the arsenic powder is table salt and sprinkles it on one’s scrambled eggs”. Actions that are involuntary are therefore roughly those actions that are automatic or forced or based on misinformation or done in ignorance. One’s action is also not fully voluntary if it is based on immature or defective faculties of reasoning (Feinberg 1971).

5.1. Ignorance

Aristotle doesn’t consider an action as voluntary when the cause (of action) is internal, in other words when the action comes about by ignorance. He distinguishes between actions *caused by* ignorance and actions *done in* ignorance. An action is

caused by ignorance if it is performed because a person *ignores* the particulars which the action consists in and is concerned with. This is the case when for example a person does not really know what he or she is doing, toward whom the action is directed or what the consequences of the performance of that action will be. As an illustration we can imagine someone who mistakenly drinks a liquid she thinks is water when it actually is poison.

In contrast, Aristotle says an *action* done in ignorance can be performed while knowledgeable of the particulars which define the action. In this case the ignorance is about universals (as opposed to ignorance about the particulars of the action). It is ignorance regarding what *kind* of action we must do or avoid. Hence actions done in ignorance are those where a person, while aware of the particulars of the case, does not know what the right or wrong, good or bad action is. For Aristotle this kind of ignorance is the cause of vice. He maintains that even though the person does not know that performing this kind of action is not right, that this is not a reason for saying he or she acted unwillingly (Aristotle 2009, Bk 3). So, for Aristotle, someone could know very well what kind of action he or she must do in certain circumstances, but, as a consequence of his or her ignorance of the particulars, not be able to perform the right action. This person will be excused, because the action performed does not indicate to us that he or she is vicious, but rather that he or she was under unfavourable circumstances, which did not allow him or her to know the particulars. On the other hand, a person who, knowing the particulars in which the actions consists, does not know what kind of action he or she must do, is blamed, since the action is an indicator of a vice in him or her.

He says that, “actions... receive praise or blame when they are voluntary, but pardon, sometimes even pity, when they are involuntary” (Aristotle 2009, Bk 3).

“Voluntary actions that are virtuous actions are to be praised” (Aristotle 2009, Bk 3). According to him, "Everything that is done by reason of ignorance is not voluntary; it is only what produces pain and repentance that is involuntary. For the man who has done something owing to ignorance, and feels not the least vexation at his action, has not acted voluntarily, since he did not know what he was doing, nor yet involuntarily, since he is not pained. Of people, then, who act by reason of ignorance he who repents is thought an involuntary agent, and the man who does not repent may, since he is different, be called a not voluntary agent; for, since he differs from the other, it is better that he should have a name of his own. Acting by reason of ignorance seems also to be different from acting in ignorance; for the man who is drunk or in a rage is thought to act as a result not of ignorance but of one of the causes mentioned, yet not knowingly but in ignorance. Now every wicked man is ignorant of what he ought to do and what he ought to abstain from, and it is by reason of error of this kind that men become unjust and in general bad; but the term 'involuntary' tends to be used not if a man is ignorant of what is to his advantage- for it is not mistaken purpose that causes involuntary action (it leads rather to wickedness), nor ignorance of the universal (for that men are blamed), but ignorance of particulars, i.e. of the circumstances of the action and the objects with which it is concerned. For it is on these that both pity and pardon depend, since the person who is ignorant of any of these acts involuntarily” (Aristotle 2009, Bk 3).

Aristotle makes a distinction between actions “caused by ignorance” and those “done in ignorance” (Aristotle 2009, Bk 3), but maintains that these do not necessarily make an act involuntary. Thus he says that "we punish a man for his very ignorance, if he is thought responsible for the ignorance, as when penalties are doubled in the case of

drunkenness; for the moving principle is in the man himself, since he had the power of not getting drunk and his getting drunk was the cause of his ignorance. And we punish those who are ignorant of anything in the laws that they ought to know and that is not difficult, and so too in the case of anything else that they are thought to be ignorant of through carelessness; we assume that it is in their power not to be ignorant, since they have the power of taking care " (Aristotle 2009, Bk 3).

5.2. Coercion

According to Aristotle if one's choice or action is compelled by external factors, then the decision or action is not a voluntary one, because "acting freely entails the ability to have done otherwise at the time of action" (Eshleman 2014). So, when the cause of the action is external to the individual, in other words, where it is not caused by the individual's own will, but comes about by coercion (sometimes also described as force or compulsion) then it is not voluntary.

Common to all philosophical accounts of coercion is the idea that coercion involves "the use of a certain kind of power for the purpose of gaining advantages over others (including self-protection), punishing non-compliance with demands, and imposing one's will on the will of other agents" (Anderson 2006). For instance in his discussion of coercion in *The Summa Theologica*, Thomas Aquinas suggests "that coercion is a kind of necessity in which the activities of one" person (the coercer) "makes something necessary for another person" (Anderson 2006). Aquinas explains that "the necessity of coercion is that in which a thing must be, when someone is forced by some agent, so that he is not able to do the contrary. Such necessity is altogether repugnant to the will" (Anderson 2006). Hence, "what is done because of coercion is not done voluntarily" (Anderson 2006). For Aquinas, "to say that something is

voluntary implies that it follows from or is in accord with one's inclinations. In contrast, coercion is linked with the notions of violence and the involuntary". According to him "we call that violent which is against the inclination of a thing... [A] Thing is called voluntary because it is according to the inclination of the will. Therefore, just as it is impossible for a thing to be at the same time violent and natural, so it is impossible for a thing to be absolutely coerced or violent, and voluntary" (Anderson 2006). Aquinas proposes two ways in which violence coerces a person: (i) when used directly against one's body (Aquinas, 1920: I.II Q6 A4) and (ii) "when used in a way that disables" one's "will" (Anderson 2006). Hence by Aquinas's account, "at least some coercion affects the" coercer's "responsibility or blameworthiness for what he does as a result of coercion. He holds that one is not to be blamed for things done non-voluntarily. Insofar as violence undercuts the voluntariness of one's" actions, one is not to be blamed for them (Anderson 2006). Interestingly on Aquinas's understanding, the threat of "violence that causes one to act from fear or to avoid that violence does not make an act involuntary" (Anderson 2006).

"Coercion is typically thought to carry with it several important implications, including that it diminishes the targeted agent's" (i.e. coercer's) freedom (control) and "responsibility and that it is" a *prima facie* "wrong and/or violation of right" (Anderson 2006). For instance, "Kant makes clear that coercion counts as a hindrance to freedom, in which respect it is similar to all violations of a person's rights but" that it "can" equally "be used to prevent other rights violations, and thus may be justified" (Anderson 2006). Since no society can effectively function without some authorized uses of coercion, "coercion is one method by which a powerful agent" (Anderson 2006) such as the state can exercise and maintain its power or dominance over its

citizens, maintain social order and achieve justice. Few if any, would therefore argue that coercion is always ethically problematic or unjustified. However because coercion involves rights interference, and because it is such a potent means available to the state, it is “prone to abuse and” therefore “something that deserves ethical scrutiny whenever it is used” (Anderson 2006).

According to Anderson (2006) “there are two traditional sorts of grounds on which” a person’s “responsibility might be truncated or attenuated because he was coerced. The first is by virtue of being excused for his action; the second is by virtue of his action being justified”. Anderson explains that, one may be excused – wholly or “in part – for an action performed under coercion if that action (or its consequences) was beyond one’s control or willpower to prevent, or if that action (or its consequences) was unintentional. This latter condition might obtain if, for instance, one acquiesces under coercion to do something intentionally (like driving a car) but in” doing “so one does something else unintentionally (like helping a murderer escape). Excuse may also be invoked when the coerced person acts in ignorance or the harm he causes is unintentional (excuses which are available regardless of whether one is coerced). One is justified in acquiescing to coercion if one’s action (or its consequences) is morally required, or is morally permissible under the circumstances even if the action will foreseeably result in harm to others” (Anderson 2006). Hence one may be justified in harming an attacker in order to save one’s own life or that of others.

“If one is restrained, incapacitated by violent means, or denied essential means to achieve a purpose, then it may be fairly obvious that one has an excuse for not doing otherwise than one did. Relying on the principle of ought implies can, when one cannot do something, this provides a good excuse for why one is not responsible for failing to do it” (Anderson 2006). What this means is that even though one has a duty

to do something one may be excused if one has good reason for not doing it. So we can excuse a person where they have a moral duty and should have acted in accordance with it, but could not do so because they were not able to do so. In these cases the person could not have chosen or acted otherwise; they had no option but to choose or act as they did.

Before concluding the discussion of voluntary choice and action, it is important to draw the reader's attention to some important details. To claim that an action is voluntary only when it depends on the person to do or not do it, is however not to claim that only those actions the person has decided to do following rational deliberation are voluntary. For Aristotle, even actions caused by non-rational feelings such as impulse and appetite, are voluntary. Otherwise, he says, we should say that neither animals nor children do voluntary actions, given that the actions performed by them are caused by non-rational feelings or instinctive or natural drives, desires or cravings (Aristotle 2009, Bk 3).

However, Aristotle holds that although the actions of children and animals are consequences of non-rational feelings, since they lack the capacity for decision-making, they are not responsible for them. Thus to say that children and animals can be causally responsible for an event, is not to say they are morally responsible, i.e. to blame for them. Although they are responsible for the action they performed inasmuch as they were the cause of the movement of their limbs, they are not responsible for performing the kind of action they performed, for they did not decide whether they wanted or not to be moved by the kind of feeling that moved them. In contrast, a normal adult person who acted based upon his or her previous decision is responsible not only for having performed the action, but also for having performed the kind of action performed, because the adult person decided, based on his or her

virtues and vices, what kind of action he or she was going to perform, and he or she is, at the same time, responsible for having the vices and virtues he or she has. What vices and virtues a person has depends on the person self, and hence the kind of actions he or she performs depends on him or her too. Thus the kind of action an adult person performs indicates his or her character and is his or her full responsibility, whereas actions of children and animals indicate their circumstances and, at best, their natural constitution, for which they are not responsible.

Aristotle believes that the kind of person we are is a consequence of the actions we do and that there is no reason why an adult person cannot change a disposition to act viciously. Because moral dispositions are alterable, by habituation, (some) actions, are always up to us. If someone has a disposition to act viciously and wishes not to have such a disposition anymore, he or she cannot abandon a vicious disposition out of his or her mere will; for this change to be possible, he or she must overcome this disposition by performing virtuous actions so that he or she can modify this old disposition by habituating himself or herself to performing different actions. Thus not every virtuous action that we perform is an actualization of a virtue; one can act virtuously without having a virtuous character (Aristotle 2009, Bk 3).

Based on the above analysis it seems reasonable to conclude that a person may, to some extent, be excused from full responsibility if they cannot make decisions, or act on the basis of incomplete or incorrect information or have no control over their actions. The wrongdoer is usually responsible in a mitigated extent for the action or its consequences. For example if I carelessly hold out my arms and unbeknown to me, there are people standing beside me, and my arms hit them, I am generally thought to be less blameworthy than someone who intentionally hit them. The same may be true if I delivered a blow to the chest of my cheating partner without knowing that I could

break her bones in so doing. I am likely to be seen to be less blameworthy than the person who intentionally kills another person. In both instances, I am thought to be less blameworthy because I lacked knowledge of the relevant facts. A person with no voluntary control over their actions or its consequences is similarly generally excused. Consider for example the case of someone who sleepwalks and breaks into another person's house. Equally, people who lack the capacities necessary to (fully) understand the moral character of their actions e.g. minor children can cause something to occur but are not to be held morally responsible for their actions quite simply because they lack capacity to make a free choice.

6. Concluding Remarks

In this chapter I've considered what it means to have moral responsibility and to be held morally responsible. I've explained that moral responsibility is generally understood to entail normative judgements about a person's choices, actions and character. It concerns the proper ascription of praise and blame, but typically blame. An important feature of moral responsibility concerns one's duties - those that one freely chooses or that one has in virtue of one's social roles. My view is that it doesn't really matter whether there is a morally significant distinction between the concepts of duty and obligations. Common sense morality recognises that we have duties in virtue of our being human and one grounded in special relationships and our social roles. The issue then is not really, if at all, a case of whether or not human beings don't already stand in special relationships to one another simply in virtue of their being human. We can accept the claim that we have duties without having to debate this question. For instance we can agree that a pregnant woman who voluntarily chooses to reproduce has duties to the fetus - whether because of their uniquely special

relationship or because we think she should take responsibility for her decisions and the outcomes thereof.

I have also shown that one's moral responsibility for something implies one's causal responsibility for that, but that the reverse is not true. In order for one to be morally responsible, one must not only have caused something (typically harm) to occur, one must also be at fault (in the wrong). Not all harms are therefore necessarily wrong in the sense that one should be blamed. Some harm may be justified e.g. killing someone in self-defence or consenting to surgery are not wrongful in the sense that we would or should hold the agents liable for causing harm. Consent and necessity can excuse one from the wrongfulness of one's actions.

Two necessary conditions for the proper ascription of moral responsibility require that a person possess the requisite mental capacity and be in control of their actions. Moral agents can have moral responsibilities and be held morally responsible for their voluntary actions, because they have the capacity to make free and informed decisions. An action is voluntary if it is within an agent's control, i.e. if it is up to the agent whether (or not) to perform it. If an agent does not have options to choose or act differently his or her choice or actions is not voluntary in the sense required for moral responsibility. Equally so if they lack full decision making capacity or make a choice based on misinformation or in ignorance. We cannot blame someone if they didn't know that their choice or action would lead to the particular result. We really cannot expect someone to choose in what we perceive to be the right way if they don't know what the right choice is.

Setting aside the controversies about whether collectives can have moral responsibility in the same way as individual human beings, it is sufficient to claim that the idea of collective responsibility is widely accepted in common morality. We tend

to ascribe moral responsibility, to judge, praise or blame collectives – be they states, corporations or organized religions – all the time in practice. Thus in spite of the philosophical issues attendant to the idea of collective responsibility we typically think that collectives such as the state can have and indeed do have obligations and can be held accountable for its actions. So, even though the idea of collective responsibility is philosophically controversial, it is not necessary for me to delve into this particular debate. It is sufficient to claim that some collectives can have moral responsibility, in other words have obligations and be held accountable. To say that a collective can have obligations is not to say that these do not entail obligations for its individual members or that individual members have the same moral responsibility. If a collective, such as the state, can hold moral obligations this entails obligations for its individual members or citizens.

One can consider the issue of moral responsibility at different levels and in different ways. One can consider it at the level of individual decision-making and action by asking about a pregnant woman's responsibility. What are her obligations if she is pregnant and chooses to continue the pregnancy? Although she may not have an obligation to keep it alive by not aborting the pregnancy, can we hold her responsible for harming a fetus that she chooses to carry to term? Although pregnant women have a right, based on autonomy and self-determination, to accept serious health risks for herself, does she have a right to impose such risks on her future child? It is one thing for a woman to drink alcohol to her own detriment, but if she is pregnant, does her reproductive autonomy extend to include the risk of harming her fetus? What are the moral implications of choosing to continue a pregnancy? Does she have an obligation to not drink alcohol if she or plans to get pregnant? Is it appropriate to describe a woman who drinks during pregnancy as irresponsible? Can we hold her accountable

for her actions if she is addicted to alcohol? To what extent, if any, might alcoholism undermine responsibility for one's actions?

At the level of healthcare one might enquire about the responsibility of physicians and others involved in the care of pregnant women. Do they have a role to play in the prevention of FAS? If so, what might these entail? What obligations do physicians have to an expectant mother? What, if any, obligations might they have for her future child? When faced with a dilemma of having to choose between their obligations to their patient and their obligations to prevent harm to others, how are physicians to weigh these competing interests? In the context of FAS prevention, how should they deal with an expectant mother who rejects or cannot comply with medical advice to abstain from alcohol during pregnancy? How are they to balance the rights of a woman with the interests of her future child, where birth is the intended outcome?

And at the level of wider society, one can ask whether and what responsibility the state, has concerning the particular problem of FAS. While we may agree that a government in a liberal and just state has a role to play in preventing FAS, defining that role is challenging, least not because we do not tend to agree on the types of state intervention to be implemented. To what extent then, if any, can the state interfere in the rights of pregnant women in order to prevent FAS (prenatal harm)? Can it compel her to behave in certain ways through for example criminalizing drinking during pregnancy or mandatory treatment for the sake of protecting the unborn child? Which ethical principles justify state interference in individual liberty?

Chapter 4: The Moral Implications of Pregnancy and the Moral Responsibility of Pregnant Women Who Choose to Carry a Pregnancy to Term

1. Introduction

The “principle of parental responsibility offers a normative standard by which to judge the decisions and actions of those who wish to become parents” (Freeman 1997:180). In terms of the principle, individuals must “attempt to refrain from having children, unless certain minimum conditions can be satisfied” (Steinbock & McLamrock 1994), notably the “conditions necessary to allow their children to have good and fulfilling lives” (Ankeny 2007). This idea can be traced back to John Stuart Mill who argues “that it is a moral crime to bring a child into this world without fair prospect of being able, not only to provide food for its body, but instruction and training for its mind” (Mill 1859, Ch. 5).

In terms of the principle, individuals, who desire to become parents, must consider the interests and welfare of the future child when deciding whether to reproduce. If there is a possibility that the child will have a life marked by severe pain and disability the principle implies that people should refrain from having children. “Anyone willing to subject a child to a miserable life when this could be avoided” (Steinbock & McClamrock 1994) would be failing to live up to a minimum ideal of responsible parenting.

The idea that there should be limitations on an individual’s right to reproduce is not uncommon. Rights are *prima facie* claims, powers or freedoms that should not be understood in absolutist terms, but rather in general terms, where the content of the

right is determined by its interaction with other rights and duties. Writers have argued that restrictions should be placed on a person's right to reproduce and hence be parents, whether for public aims or because the exercise of the right posits duties that may limit the right. Hugh LaFollette (1980) for instance endorses a programme for licensing parents, whereas Julian Savulescu (2001) argues that the principle entails a duty of procreative beneficence, which requires parents to always choose to have the best possible child.

However, even though one may assume "a range of responsibilities in making a decision to reproduce, including consideration of the conditions that should be in place to bear and rear a child, there are no obvious objective norms for ideal childrearing conditions" (Ankeny 2007). While people generally would agree that parents and those who wish to become parents should consider the interests of their future child, what precisely parental responsibility requires of them is contentious.

John Harris (1990) explains that the problem is split in two. "The first involves an examination of potential children for their adequacy as children and the second involves examining potential parents for their adequacy as parents.... One dimension of the problem involves asking whether we might do wrong by bringing particular children into existence because of problems relating to...the constitution of those children, in virtue of which we might expect them to have less than adequate or satisfactory lives. The second concerns the question of whether we might do wrong by permitting children to be brought into existence who will suffer from less than adequate parenting" (Freeman 1997:173).

The complexity of the questions "and the dilemma of understanding what is meant by acting in a parentally responsible manner" (Freeman 1997:173) are illustrated in two contrasting examples that Derek Parfit (1976) invites us to consider. The first example

is of a woman who is one month pregnant and told by her physician “that, unless she takes a simple treatment, the child she is carrying will develop a certain” disability (Freeman 1997:174). Life with this disability would probably “be worth living, but less so than normal life” (Freeman 1997:174). According to Parfit, it would be wrong for the mother to refuse the treatment because it will mean that her child will be disabled. The second case that Parfit provides is of “a second woman, who is about to stop taking contraceptive pills so that she can have another child. She is told that she has a temporary condition such that any child she conceives now will have the same handicap” (as the child in the first example), “but if she waits three months she will then conceive a normal child” (Freeman 1997:174). For Parfit (1976:76), “it would be just as wrong as it would be for the first woman to deliberately handicap her child” (Freeman 1997:174).

Parfit explains that the first case is relatively uncontroversial because the principle of parental responsibility instructs the woman to prioritise her child’s wellbeing, hence take treatment for the sake of her child, but that the second case is far from straightforward (Freeman 1997). He illustrates this point with another example that involves a teenage girl who wants a baby. He says that we may, in an attempt to persuade her to delay having a child, say to her “You should think not only of yourself but also of your child. It will be worse for him if you have him now” (Freeman 1997:175). He points out that the “weak link in this claim is the phrase ‘worse for him’, for clearly if she has a child later it will not be the same child” (Freeman 1997:175), hence it can be neither worse nor good for him. He acknowledges various consequentialist arguments why teenagers should not have babies, but maintains that “having a child cannot make *that child*” that she is contemplating “better off by waiting” (Steinbock & McClamrock 1994). If she delays childbirth, the child that she

will ultimately give birth to will be a *different* child, because it would have developed from a different egg and sperm (Steinbock & McClamrock 1994). The child that the teenage girl “will have if she becomes pregnant now cannot be born at a later time. It is either birth to a teenage mother or no life at all” (Steinbock & McClamrock 1994). Steinbock and McClamrock (1994) explain that “If we maintain that it is for the sake of the child she would bear that she should avoid pregnancy, we seem to be committed to the view that it would be better never to be born at all than to be born to a very young mother”. Parfit (1984) argues that “although being born to a teenage mother isn’t ideal, we” can’t really say that her having a child is so bad as to make nonexistence preferable, in other words, that children would be better off if their parents did not have them.¹⁵ He says that despite the hardships that children may undergo or the fact that they may have “preferred having an older mother, most children of very young mothers are probably glad they were born” (cited in Steinbock & McClamrock 1994)

Although many people may agree that a woman has rights, based on autonomy and self-determination, to reproduce (or not) and to accept serious health risks for herself, what is less clear and arguably more contentious is whether she has a right to impose such risks on her future child. Even if the fetus has no or little rights, where a woman has chosen to carry a pregnancy to term, does it mean that she can behave as she wishes during her pregnancy? Does a pregnant woman’s alleged sovereignty over her own body (right to bodily integrity) imply a right to take serious health risks, even to the extent that it amounts to undeniable harm to her future child? What, if any, obligations does she have toward her future child? Does she have a compelling duty to abstain from alcohol? Can we rightly hold her morally responsible if she continues

¹⁵ Note, however, the argument developed by David Benatar that to produce an offspring is always morally wrong (Benatar 2006a: 18-59.)

to drink despite knowing the risk to her child? What if she is an alcoholic? Does alcoholism diminish one's moral responsibility? Does it excuse her actions and the consequences thereof? Is drinking during pregnancy wrong and irresponsible behaviour on the part of a woman? Do we have reasonable grounds to morally judge and to blame her? And where she is at risk for having a child with FAS, should she terminate her pregnancy?

2. The Moral Implications of Choosing to Continue a Pregnancy

A moral implication of choosing to continue a pregnancy is that the woman can be said to be (one of) the child's parents. A common and relatively uncontroversial view is that parents are the man and woman who were involved in the procreative act that causally resulted in the conception of the child (Blustein 1997; Nelson 1991). Typically this view places parenthood or being a parent on the nexus of genetic or biological relations such as being a child's mother, father, a sibling, an aunt, a cousin and so on. This account, however, does not necessarily accommodate those individuals who do not get pregnant through conventional methods but who conceive through assisted reproductive techniques such as IVF and surrogacy. It also does not accommodate those individuals, who may have no genetic ties to a child and, who may not be causally responsible for the child coming into existence, but who may wish to become parents through adoption. At the same time it makes parents of people who may not necessarily want to be parents. There is a morally significant difference between being a pregnant woman and being a child's mother. Pregnancy and motherhood, although often related, are distinct positions. The mere fact of being pregnant does not automatically make the woman a mother. Just because she is

pregnant does not necessarily mean that she wants to take on the burdens of parenthood.

A more plausible account of parenthood relates to the actors' intentions about reproduction. In terms of this view parents are not only those individuals with genetic ties to the child or who have caused the child to be conceived, but also those individuals who intend to have the child (Hill 1991; O'Neill 1979). Theorists such as Sydney Callahan claim "the meaning and value of fetal life are constructed by the woman and that without this personal conferral, there only exists a biological, physiological process" (Callahan 2009:125). Similarly, Deborah Mathieu (1991:14) argues that "Once a pregnant woman forgoes her right to have an abortion, then, it could be argued that her actions should be constrained by considerations of the welfare of the child that the fetus will become" (Mathieu 1995:47) and that she "incurs these moral obligations to her future child only if she intends to carry the fetus to term" (Mathieu 1995:47) And Kathleen Nolan (1990) argues that "a pregnancy which is expected to result in the delivery of a child generates moral obligations based on the consequences to that child of actions and events that occurred during the prenatal period".

This "intention to carry a fetus to term" view has the advantage of accommodating even those individuals who adopt children and restricting parenting to only those individuals who freely choose to bear children. This account of parenthood recognises that a woman is free to choose and intend to have a child and thus be the child's parent when she has socially acceptable options of avoiding pregnancy and birth by abstaining from sex, practicing contraception and terminating a pregnancy. Prior to a pregnant woman's own free choice to carry a fetus to term she cannot be described as a mother and consequently be expected to behave like one, and neither can a child be

said to exist. However once she chooses to carry a fetus to term, she becomes a prospective mother with moral obligations to her future child.

Normal adults are presumed to have the capacity to reflect on their situation and to form intentions about how they will act. They are thought capable of choosing whether or not they will reproduce. Irrespective of how a pregnancy may come about – i.e. voluntarily or not¹⁶ - where women have the option to not reproduce, they can still be said to intend reproduction and thus choose to cause a child to come into existence.

In South Africa, women can be said to be able to choose whether or not they will reproduce or accept the burdens of parenthood, because they have a right to an abortion. *The Choice on Termination of Pregnancy Act* (No 92 of 1996) is the primary piece of legislation governing abortion in the country. In terms of the Act, a woman of any age may request an abortion during the first 12 weeks of pregnancy, provided she understands the consequences of her choices. Thereafter conditions apply. From the 13th week up to and including the 20th week of the pregnancy, abortion is permitted, only “if a medical practitioner, after consultation with the pregnant woman, is of the opinion that-

- (i) the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or
- (ii) there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality; or
- (iii) the pregnancy resulted from rape or incest; or
- (iv) the continued pregnancy would significantly affect the social or economic circumstances of the woman” (section 1).

¹⁶ Even where abortion is optional, some women whose pregnancies may for instance have come about as a consequence of rape or other forms of sexual assault may still choose to continue a pregnancy.

After the 20th week of pregnancy abortion is permitted only “if a medical practitioner, after consultation with another medical practitioner or a registered midwife, is of the opinion that the continued pregnancy-

- (i) would endanger the woman's life;
- (ii) would result in a severe malformation of the fetus; or
- (iii) would pose a risk of injury to the fetus” (section 1).

Generally, “no consent, other than that of the pregnant woman is required for a termination of pregnancy” (section 5). However, if she is a minor – in South Africa, this is under 18 years of age – “the medical practitioner or midwife” must “advise” her “to consult with her parents, guardian, family members or friends before the pregnancy is terminated” (section 3). She cannot however be denied an abortion if she refuses to do so.

Where the woman is “severely mentally disabled to such an extent that she is completely incapable of understanding and appreciating the nature or consequences of a termination of her pregnancy, or where she is in a state of continuous unconsciousness and there is no reasonable prospect that she will regain consciousness in time to request and to consent to the termination of her pregnancy”, the termination may be performed upon the request and with the consent of her natural guardian, spouse, legal guardian or curator, as the case may be (section 4)’

Given that women qualify for a lawful termination of a pregnancy in a variety of circumstances for a myriad of reasons, it seems reasonable to conclude that they can choose whether they will carry a fetus to term, i.e. be prospective mothers of future children. A moral implication of the decision to continue a pregnancy is that the pregnant woman now stands in a special relationship with the child; a relationship that generates moral obligations for her toward her future child.

One particular problem with my proposal relates to women's access to abortion services in the country. Although women have a legal right to an abortion, this does not mean that they have adequate access to the service. A combination of factors, including medical professionals' opposition to and fear of being stigmatised for providing abortion and related services, poor knowledge of abortion legislation, as well as a shortage of abortion services and trained providers to perform abortions, serve to hamper women's access to abortion services (Harries, et al. 2014; Harrison, et al. 2000; Jacobs & Hornsby 2014; Trueman & Magwentshu 2013). One study for instance reports that fewer than 50% of public health facilities that are licensed to provide abortion services are actually doing so (Trueman & Magwentshu 2013).

Conscientious objection is a particularly "important issue in understanding the obstacles associated with implementation of and access to legal abortion services" (Jacobs & Hornsby 2014:857). In South Africa, medical professionals have a constitutional right to object to providing services to women seeking to access legal abortion, on the basis of their moral belief, religion or conscience¹⁷, but are legally obligated to provide the service in an emergency. However, even when they object, they are legally obligated to inform women and refer them to an alternative facility, but may not do so, if they believe even these services to be objectionable (Jacobs & Hornsby 2014). These practices implicate and undermine women's free choice concerning their decisions about reproduction and continued pregnancy status. However, it does not mean that women are completely unable to secure a medical professional or facility willing to assist them; it just makes the process of obtaining

¹⁷ In terms of section 15(1) of the Bill of Rights contained in the *Constitution of the Republic of South Africa* (1996), "Everyone has the right to freedom of conscience, religion, thought, belief and opinion."

the service challenging.¹⁸

3. Moral Obligations to Future Children

A woman who chooses to continue a pregnancy is exercising her right to reproduce as much as the woman who chooses not to do so. Upon choosing to be a prospective mother, she now stands in a special relationship with her future child and can be said to have special obligations to not harm and to benefit her fetus - hence future child.

The proposition that we can have obligations to not harm future children is not a bizarre one. Ordinarily we recognize that a wrongful act done today may harm individuals in the future.

Harper and James (1956:1030), provide the following example to illustrate the point. They say that “the improper canning of baby food today is negligent to a child born next week or next year, who consumes it to his injury”. Joel Feinberg (1984) similarly explains how it can be that future children can be harmed. To support his claim, he cites an example of a negligent motorist who runs over a pregnant woman, which results in harm or wrong to the born child (Mathieu 1995:2; Mathieu 2007:2). Feinberg (1984) explains that “The child comes into existence in a harmed state caused by the earlier negligence of a motorist whose act initiated the causal sequence, at a point before actual personhood, that later resulted in the harm. The motorist’s negligent driving made the actual person who came into existence months later worse off than she would have been. If the motorist had not been negligent, the child would have been born undamaged” (cited in Steinbock & McClamrock 1994).

¹⁸ Women can for instance obtain one in the private sector albeit at a cost or bear the costs of travelling to far-away locations where the service can be accessed.

Finally, Jen Saugstad (1994) illustrates how, in the context of environmental ethics, it can be that we can have moral obligations to not only contemporary but also to future generations. In Saugstad's example "terrorists launch a nuclear missile that is set to remain in orbit for two centuries" (Saugstad 1994). After this time, the missiles will fall upon a "country, and kill all of its citizens" (Saugstad 1994). Saugstad's point is that we have a moral obligation to not act in ways that will harm future people, because "being like us, future people will also have important personal interests – including interests that we have the power to affect by our choices" (Saugstad 1994). So for Saugstad (1994), whenever our free actions can significantly harm others or their important interests, we have a *prima facie* moral obligation to not act in that way. Consequently it is reasonable to suggest that prospective mothers have a *prima facie* moral obligation to not harm their fetuses, because it is the resultant children that will suffer the fate of their choices.

But while the idea that we have obligations to not harm others is relatively uncontroversial, the idea that we have positive obligations, grounded in beneficence, to promote the welfare of others is arguably more contentious. Understood as a rule or duty, the principle of beneficence implies that we are to perform acts such as mercy, kindness, and charity and avoiding causing harm to others because doing so serves to benefit or promote their good. Understood as a virtue, the benevolent person is one who is disposed to act for the benefit of others (Beauchamp 2008). Beneficent acts can therefore be performed either from obligation (a sense of duty) or from non-obligatory, optional moral ideals of action and excellence as the term benevolence

suggests. An often cited example of non-obligatory beneficence is the New Testament parable of the Good Samaritan contained in the Bible.¹⁹

The extent to which beneficence or “doing good to others” is morally required (i.e. is obligatory) is vigorously debated in moral philosophy (Beauchamp 2008). Some commentators, like Robert Nozick (1974) for instance argue that there is no such moral duty, but that beneficence is better understood as a morally commendable virtue. Others like Phillipa Foot (1980) point out that, even if we have a duty of beneficence, the duty to avoid harm has priority over doing good; in other words that the obligation not to harm people is more stringent than the obligation to benefit them. So while we can require people to not harm others, we cannot require them, in the same way, to do positive acts to benefit others. In practical terms this means that while we may have a duty to not drown someone we have no duty to save them if they are drowning. It may of course still be beneficent of us to save them, but not because we have a duty to do so but rather because we choose to do so regardless of whether we have such a duty. Acts that exceed or go beyond the obligatory requirements of ordinary morality or professional morality, and are performed for the benefit of others, are supererogatory acts (Beauchamp 2008).

Even though we may agree that a prospective mother has a positive obligation (grounded in beneficence) to consider and act in the interests of her future child, we may still disagree about what this means or implies for her conduct during pregnancy. What does it mean to harm someone? And does the duty to prevent harm mean that a woman must always do whatever is necessary to prevent and remove all possible harms to her future child?

¹⁹ In this parable a Samaritan comes across a stranger (a Jew) in need of assistance and tends to his wounds and care for him at an inn. The Samaritan was not obligated to help (since Samaritans and Jews in New Testament times were regarded as mortal enemies), but did so anyway and at significant cost or sacrifice to himself, since he also carried the cost of the Jew’s care when he could no longer look after the Jew himself.

3.1. When Do We Harm Someone?

Common morality recognises that harms are not necessarily wrongs; that only some kinds of harms are also a class of wrongs, for which one can rightly be held responsible. Philosophers as far back as John Stuart Mill (1863) recognise that “we do not call anything wrong, unless we mean to imply that a person ought to be punished in some way or other for doing it; if not by law, by the opinion of his fellow-creatures; if not by opinion, by the reproaches of his own conscience” (Mill 1863, Ch. 5). So it is not always the case that if someone is harmed that they have been wronged or that the person who caused the harm should be held responsible for it. Sometimes harmful acts and outcomes are justifiable. For example, suppose a lifeguard, in an attempt to save the life of a drowning person, breaks the person’s arm. Although the person suffered harm in the form of a broken limb, it does not follow that the lifeguard should be blamed for it. We can acknowledge that the lifeguard acted out of necessity in order to save the person’s life. We tend to think that a reasonable person would most likely want to be saved (i.e. be alive, even perhaps in a disabled condition) rather than dead; that sometimes harm is a consequence of aiming for a presumed greater benefit, as is the case when a patient consents to invasive medical procedures that aim to improve the patient’s condition, rather than make the patient worse off.

Philosophical accounts of harm generally rely on a notion of harm that compares a person’s current condition with that which he would otherwise have been, had it not been for the harmful event. For example, Joel Feinberg (1984) defines harm as the “thwarting, setting back, or defeating an interest”, where interests are defined as “those things in which one has a stake... [these] are distinguishable components of a person's well-being: he flourishes or languishes as they flourish or languish” (cited in

Steinbock & McClamrock 1994). By his account people generally have a stake or an interest in something that they stand to gain or lose. Something is therefore in one's best interest if it is good or beneficial for one and against one's interests if it is bad or harmful to one.

Feinberg suggests that the "minimal conditions of wellbeing amount to a requirement that we not doom the child's future interests to total defeat. The advance dooming of a child's most basic interests – those essential to the existence and advancement of any ulterior interests – deprives the child" of what Feinberg calls the child's "birthrights" (Steinbock & McClamrock 1994). According to him, "if the conditions to enable a child to fulfil his most basic interests are destroyed before he is born and we permit him nevertheless to be born, we become party to the violation of his rights" (Freeman 1997:167).

Feinberg explains that "Before the fetus becomes a person it is a potential person with the potential attributes, including the possession of rights of a person" (Feinberg, 1994:24). "If the potential person has an unalterable destiny of extreme impairment and suffering, and if one of the rights the child will have at birth (at the presumed onset of personhood) is the right to be free of these total impediments to development and fulfilment, then the potential rights at the very moment they are actualized are violated" (Feinberg 1995:24).

So, according to Feinberg, a severely disabled child is born "not simply with rights but with already violated rights" (Feinberg 1995). Disabilities generally violate what Feinberg (1980) calls "the child's right to an open future". According to Feinberg an open future is one where a child can become capable of choosing his or her own conception of the good. So, from the moment the child is born, the child "has a grievance, a claim that he has been wronged" (Feinberg 1995). Harm is "caused to a

person before birth in virtue of the later interests of the child that can already be anticipated” (Steinbock & McClamrock 1994). On Feinberg’s account of harm and from the standpoint of the future child, it is wrong to have a child when the minimal conditions of well-being cannot be assured.

John Harris (1989), similarly argues that the desire to found a “family is constrained only by consideration for the fate of the children who will constitute that family” (Freeman 1997:179) and that where children will be severely disabled, there “may be an obligation not to bring them into existence or allow them to continue in a world where their existence will be genuinely terrible” (Freeman 1997:179). Harris defines harm as simply being “put in a condition that is harmful” (Harris 1990:97). For him, a condition is harmful if the individual is disabled or suffering in some way or if their interests or rights are frustrated. Harris (1990:98) explains that “Where B is in a condition that is harmed and A and/or C is responsible for B’s being in that harmed condition then A and/or C have harmed B”, in the sense that they not only harmed B but have also wronged B.

Seana Shiffrin (1999:124) further explains that “To be harmed primarily involves the imposition of conditions from which the person undergoing them is reasonably alienated or which are strongly at odds with the conditions she would rationally will; also, harmed states may be ones that preclude her from removing herself from or averting such conditions.” On this view, death, pain, disabilities, injuries and illness qualify as harms. If these conditions are forcibly imposed on others, contrary to their will, they constitute harms. These unconsented to conditions are also harms because “they impede significantly one’s capacities for active agency and for achieving harmony between the contents of one’s will and one’s” life more broadly understood (Shiffrin 1999).

It might appear to be inconsistent to allow a pregnant woman to sever her relationship with the fetus entirely through abortion, but argue that she has a moral obligation to not harm her fetus and perhaps even sometimes to choose to not have a child. Thus some people might ask: How can we hold a woman responsible for injuring or damaging a fetus but not for terminating its existence? Isn't death/destruction a graver, more serious harm than impairment? These sorts of questions however miss a fundamental distinction. While abortion considers the fate of usually unwanted pregnancies, the cases that this dissertation is concerned with are pregnancies that women have "chosen" or "accepted" to continue to term, with the intention of giving birth to a child. At issue is not the question of whether or not women should be allowed to terminate their pregnancies, but rather what sorts of obligations prospective mothers may owe their future children. If a woman opts to continue a pregnancy, where abortion was possible, does it mean that she can act as she pleases, regardless of how her behaviour will impact on her future child? To consider these questions one does not have to necessarily consider in detail the fundamental and controversial question that abortion gives rise to, viz. that of personhood or the moral status of the fetus. One could plausibly argue for the permissibility (or not) of abortion on grounds other than rights. As was previously shown, it is possible to argue that a woman's intent determines whether or not the fetus will have future interests and therefore has present interests, albeit developmental in nature. The concepts intention, freedom, and responsibility are interconnected. A person who acts freely is usually understood to act with intent, and one can be held responsible for one's intended actions and outcomes.

A woman who chooses to continue a pregnancy and who drinks during pregnancy places her future child at risk for FAS. As a prospective mother she can be said to

have both *prima facie* negative and positive obligations to her future child, which includes a duty to not harm her future child without justification and a duty to prevent or minimise harm to her future child by taking positive steps such as going for regular antenatal check-ups and taking necessary vitamins, that will benefit the child. For the purposes of this dissertation it is not important to debate whether or not a woman's duty to not harm others outweighs or takes precedence over any duties grounded in beneficence. We can accept that parents can have both natural duties and special obligations without being committed to thinking that one or the other must take priority. It is also quite plausible to think that the duty to not harm others implies a positive act to prevent harm to them, and vice versa. But while a woman's moral obligations to her future child "may be particularly broad and deep, they do not overwhelm other considerations in all circumstances" (Murray 1991:107). Sometimes those obligations must be weighed against those that she has towards herself, and others e.g. her other children and sometimes concern for her other obligations may even lead her to opt for a termination of pregnancy.

Prenatal alcohol exposure is clearly harmful to a child. FAS reduces, instead of increases, a child's chance for normal development and existence. A prospective mother can prevent the occurrence of FAS by abstaining from alcohol for the sake of their future child, but it is unreasonable to require her to always prioritise the child's best interests, i.e. to claim that her duty of beneficence is an absolute one that should always take precedence when it conflicts with other interests, rights or duties. There are many competing interests in a person's life. Most times there may not be a conflict of interests between those of the women and those of her fetus, but sometimes the woman's interests may conflict with those of her fetus. For example as may be the case when a pregnant cancer patient is faced with the option of taking treatment that

could give her the best chance of survival but kill or deform her fetus. Common morality does not require parents to protect their children from all risk of harm; only that they take necessary or reasonable steps to protect their children from harm. We cannot expect prospective mothers to take extraordinary measures or do absolutely everything or all that is necessary to protect the life and health of their future children, particularly since we do not place such high demands on parents of already born children. As Judith Jarvis Thompson convincingly argues, “no one is morally required to make large sacrifices in order to keep another person alive” (Thompson 1971). We do not for example morally require that parents donate a much needed organ to save the life of their child. We may frown upon a parent’s refusal to do so, but we do not generally think that they have a duty to do so.

Of course we may disagree about the particular risks and the steps that parents should take to protect their children from harm or what constitutes acting in or promoting their child’s best interests, the point is however, simply that we do not, at least, as a rule, expect parents to always do absolutely everything or the best possible thing for their children. To require women to do so would be to treat them as no more than fetal containers (Annas 1986; Purdy 1990). “Since we do not force medical interventions on anyone in order to save another fully developed, rights-bearing person, a double standard that allows forced interventions on pregnant women seems to enshrine the fetus as *more* valuable and deserving of protection than born persons” (Kukla & Wayne 2011).

4. Does Alcoholism Diminish Moral Responsibility?

Ordinarily we call people who are addicted to or dependent on alcohol, alcoholics, and the condition, alcoholism. However, defining the condition of alcoholism in a

satisfactory way is not an easy task, as there are different conceptions of how we understand it (WHO 1994).

Alcoholism presents a particular set of challenges for moral responsibility. Dominic Wilkinson (2010) illustrates the problem that alcoholism poses for moral responsibility with an analogy involving a hammer and a nail. The analogy begs us to consider whether the addict is “akin to a hammer – responsible for the action that ensues? Or are they like the nail – driven by forces out of its control?” Wilkinson’s illustration of the problem highlights several ethical questions: Do alcoholics have moral responsibility? Can they be held morally responsible for their choices, actions and character? Do they freely choose to drink or are their actions compelled? Does alcoholism diminish moral responsibility? Does it reduce a person’s capacity for decision-making and voluntary action? Do alcoholics have options to choose from or are they not in control of their choices and actions? Does alcoholism diminish a person’s free choice and action? Is their decision-making capacity impaired? And to what extent, if any, are biological, psychological and environmental factors morally relevant in deciding whether or not an alcoholic can and should be held morally responsible? Before considering these questions, it is necessary to say something about the different conceptions of alcoholism and their relevance to moral responsibility.

4.1. Conceptions of Alcoholism

Views on alcoholism fall roughly into one of four positions, viz., the willpower or moral model, the disease or medical model and the lay position (Foddy & Savulescu 2010). The main differences that arise out of these models are the causes they attribute to alcoholism and the role of free will.

The willpower model

The willpower model is arguably the oldest account of alcoholism, which according to Wilbanks (1989), emerged as a result of the significant influence of religion in people's lives. Consequently, this position of alcoholism is rooted in the idea that alcoholics wish to "abstain, but their will is not strong enough to overcome an immediate desire to temptation" (Foddy & Savulescu 2010). In terms of this view, alcoholics are merely weak-willed people who should act otherwise, but lack the moral character or motivation to do so (Pickering 2006).

The weakness model appeals to our common sense because it is consistent with our notions of free will and individual autonomy. Alcoholics are seen as free-willed individuals who make rational choices to consume alcohol, and alcoholism, a choice based on bad values. The implication of the willpower model is that people is that people are responsible for creating and solving their problem.

The willpower model can be traced back to Aristotle's discussion of an *akratic* (i.e. incontinent) person. In his *Nicomachean Ethics*, Aristotle (2009) describes an incontinent person as someone who cannot master his or her passions and lacks a required character disposition, viz. self-control. To remedy the deficiency or inability to choose differently, Aristotle argues that the incontinent person must regain or develop self-control. In Christian ethics, alcoholism is also understood in terms of sin and virtue, vice and godliness (Madueme 2008). Lack of self-control and weakness of will or lack of willpower are generally seen as moral dispositions and feelings to be avoided with divine help. One shortcoming of the willpower model is its failure to sufficiently capture the phenomenon. For example, it does not seem able to account for how even people with good or strong morals can and sometimes do become

alcoholic. Consequently it ignores the range of social and psychological factors that influence alcohol use and alcoholism.

The disease model

In contrast to the willpower model, the disease conception of alcoholism sees alcoholism as “a condition of primary biological causation and predictable natural history, conforming to accepted definitions of a disease” (WHO 1994). Alcoholism is seen to be a consequence of physiological changes – i.e. a desire to consume more - that drinking may cause (Wilbanks 1989).

The disease model views alcoholism as a disease and alcoholics as victims of disease, and patients that require treatment. Underpinning this view is the belief “that there is some normal process of motivation in the brain and that this process is somehow changed or perverted by brain damage or adaptation caused by chronic drug use” (Savulescu & Foddy 2010). The alcoholic is no longer rational and consumes alcohol as a result of a fundamentally non-voluntary process because he or she has no choice but to drink. Leschner (1999; 1997) and Hyman (2007; 2005) have for instance defended the view that an alcoholic’s “actions are the direct result of brain adaptations caused by chronic drinking and that their actions are more like reflexes than rational behaviors” (Foddy & Savulescu 2010:2).

The disease-model, in particular, highlights the questions concerning alcoholics and moral responsibility, because it implies that alcoholics cannot be responsible for their addictive acts because their addiction to alcohol (chronic drinking) is a disease, i.e. something over which they do not have proper control, at least in the sense necessary for moral responsibility. This view challenges the traditional understanding that normal adults have control over their choices and actions, and gives rise to a situation or phenomenon that Buchman, et al. (2010) refer to as “the paradox of neuroscience”.

This “paradox” is that while the disease-model of alcoholism gives alcoholics access to treatment and support as well as compassion from other people, it, at the same time, also undermines an alcoholic’s moral responsibility because it views the alcoholic’s capacity for free choice and action, as fundamentally different to that of non-alcoholics. Because they suffer from a disease (i.e. alcoholism) and because the alcoholic’s neurobiological and pharmacological mechanisms differ substantially from that of non-alcoholics, we cannot therefore condemn them because of their habits or hold them morally responsible. Because alcoholics cannot choose otherwise, they have no control over their actions and therefore cannot be held responsible. Rather than blame, condemn or otherwise punish the alcoholic, the alcoholic should be handled in accordance with this characterisation.

Like the willpower model, the disease model has been criticised. The implication of the disease model of alcoholism is that alcoholics cannot be held responsible for their alcoholism because they are compelled to drink and consequently have reduced or no control, in the sense required for responsibility ascriptions. On this conception, the alcoholic is no more responsible for their condition than say a cancer patient. The implication of the disease model is that alcoholism could be “used to excuse wrongdoing or to exculpate individuals from responsibility for their actions. After all illness implies incapacity of some kind over which an individual has no control” (Bonnie 2002:252). Consequently, the disease model has been criticised for taking responsibility away from alcoholics by characterising alcoholics as victims. Furthermore, Bonnie (2002) describes the model as being incomplete and premature. “Incomplete because it fails to communicate the whole story about the behavioural and contextual components of addiction... [and]... premature, because research has not connected the observed changes in the brain to behaviour.... It is still not possible

to explain the physiologic and psychological processes that transform the controlled use of drugs into addiction” (Bonnie, 2002:406).

Lay view

Finally, the lay account of alcoholism holds that people consume alcohol “because they are morally corrupt hedonists who value immediate pleasure above all else and who rely on others to handle their ensuing health and survival difficulties” (Foddy & Savulescu 2010). By this account of alcoholism, alcoholics are rational agents who act on normative reasons and simply choose the pleasure (and pain) of alcoholism. Alcoholism is “nothing more than a species of strong appetite” (Foddy & Savulescu 2010) or desire toward pleasure behaviour. Alcoholics are not necessarily incompetent or impaired in their decision-making capacity. In a sense they may be described as rational agents making irrational choices. On this view, the best solution to alcoholism is for alcoholics “to choose to accept their responsibilities” (Foddy & Savulescu 2010).

4.2. Alcoholism and Moral Responsibility

Alcoholics are usually thought to be somehow out of control of their actions. It is thought that they cannot abstain from alcohol and are somehow forced to satisfy their desire or “need” to drink. The WHO defines it as “chronic continued drinking or periodic consumption of alcohol which is characterised by impaired control over drinking, frequent episodes of intoxication and preoccupation with alcohol and the use of alcohol despite adverse consequences” (WHO 1994).

A common attitude may therefore be to assume that moral responsibility can be reduced or diminished in virtue of being alcoholic or suffering from alcoholism. Underlying this thinking is the idea that people are not entirely to blame for what they

do because they have no control of their actions because they have no option but to do what they did. The effect of this, i.e. holding that alcoholics have little or no control, is however that it reduces the moral responsibility of everybody to zero. In the final analysis the person ends up bearing no moral responsibility for their actions, which of course, is problematic, if we believe that normal adults have, at least some, agency or control over their decisions and actions.

There are additional reasons for thinking that alcoholism does not reduce a person's moral responsibility, and consequently, that they have control over their choices and actions. Firstly, if we regard compulsion as being simply about the strength of a desire or urge and a binary property (i.e. an action is either compulsive or not), and not a matter of degree (i.e. an action is more or less compulsive), then alcoholism, in general, is not compulsive in the sense that alcoholics absolutely lack choices to act otherwise (Uusitalo 2011:83). Alcoholics have at least two alternative possibilities in their reach: to drink or not to drink alcohol. When sober, they can choose whether to satisfy their desire. Of course it is relatively easier to abstain from a single act of drinking than it is to change the pattern of behaviour involved in alcoholism. But it is not absolutely impossible for an alcoholic to choose to not satisfy their desire to drink. Although it may be difficult to change the pattern of behaviour in alcoholism, every act of abstinence can potentially lead to behaviour change. Moreover, some alcoholics do overcome their addictions, sometimes without help. This suggests that, at least some, alcoholics can choose to not drink, despite having an immense urge to drink.

A final reason for thinking that alcoholics have control necessary for moral responsibility relates quite straightforwardly to the view that many people may choose to drink alcohol because they crave alcohol more than anything else. As Foddy and Savulescu explain that, "Even though the choice to take drugs can produce extremely

deleterious consequences, we cannot infer from this fact that addictive choices are involuntary without making unwarranted assumptions about a person's ordering of values. In particular, it should never be assumed that a person would prefer to preserve their health or life rather than obtain some strongly desired outcome.... Addicts might seem non-autonomous on these accounts, because they prefer a range of imprudent outcomes – but this does not distinguish them from non-addicted, imprudent people... we must accept that there is a possibility that drug taking is her highest most prized-value, and we must treat with skepticism any claim of a thwarted desire for abstinence. We must accept that drug taking may be a preference she endorsed after reflecting on relevant facts and considering the alternatives.... Addiction cannot be defined as a condition that reduces autonomy or self-control” (Foddy & Savulescu 2010:14-15).

Alcoholism does not completely cancel out a person's capacity for reasoning and decision-making, even if the person's ability to rationally manipulate information is affected momentarily, because they are under the influence of alcohol. Even if alcoholism impairs a person's reasoning ability, this does not mean that the person lacks the capacity to understand and appreciate the initial choice they made to drink alcohol. Even though we may judge alcoholics' decisions to (continue to) drink to be irrational or unwise, this does not mean that they have no authority over themselves or their actions or that they lack options. Strong emotions, sensations and desires affect our practical reasoning in all human behaviour, not just in the case of alcoholism (Uusitalo 2011:85). Thus the suggestion that alcoholics do not freely choose their actions is dubious. It is more accurate to claim that alcoholics find it abnormally difficult, rather than impossible, to resist the desire or craving to drink. Even if alcoholics (do) lack (full) control over their actions -because their actions are

compelled by something beyond their control and they therefore cannot choose otherwise than to satisfy the desire - we can still argue that they are responsible for their alcoholism (becoming alcoholic) and thus their absence of control. It is not obvious that alcoholism excuses one from moral responsibility. Alcoholism may explain why one did what one did, but it does not mean that the behaviour is excusable or that one cannot be held responsible for one's actions and the consequences thereof. For example, people who drive while under the influence of alcohol are penalized regardless of whether the individual is alcoholic.

5. Do Prospective Mothers Have a Duty to Abstain from Alcohol?

So far I have shown why normal adult alcoholics can be thought to have control in the sense required for moral responsibility and therefore be held morally responsible for their actions. It is not obvious that alcoholism does and should excuse one from moral responsibility. The mere fact of being diagnosed with alcoholism does not negate or diminish an otherwise competent adults' capacity for free choice and action; it only explains or helps us to understand why someone may have acted as he or she did.

Alcoholism may explain why one did what one did, but it does not mean that the behaviour is excusable or that one cannot be held responsible for one's actions and the consequences thereof. Alcoholism does not appear to generally justify one's wrongdoing or (risk) harming of others. For example, society holds accountable and punishes a person who drives or injures another while under the influence of alcohol, regardless of whether the individual is alcoholic. So, even if the children of women who drank during their pregnancies are not born with FAS, we may still ask whether taking such risks is morally responsible behaviour. The answer does not depend on

whether harms actually occur. Bonnie Steinbock (1999) illustrates this point through the use of an example. She explains that “it is irresponsible to leave young children unsupervised, because of what might happen, regardless of whether any harm in fact befalls them. It is irresponsible to have loaded guns where children might get them, even if no child ever does” (Steinbock 1999: 376). Thus it is not so much whether a child in fact suffers harm or damage, but rather a question of whether it is (ir-)responsible of parents to place their children at risk of harm. Even if a child suffers no damage as a consequence of prenatal exposure to alcohol, it still does not settle the issue of whether maternal drinking during pregnancy is a responsible one. Women’s decisions to drink during pregnancy can therefore still be judged to be morally irresponsible.

Setting aside the myriad of factors that foster maternal drinking and increase a woman’s chances for having a FAS baby, if a woman’s child has FAS, maternal drinking during pregnancy is undoubtedly the most significant and direct causal factor. She is therefore (partly) responsible for causing the child’s harmed condition. It is therefore not unreasonable to suggest that a prospective mother has a *prima facie* duty to abstain from alcohol, at least for the duration of her pregnancy, given that FAS can be prevented without unreasonable cost or risk to herself. However to say that women have *prima facie* moral obligations to benefit and not harm their future children is not to suggest that these obligations should be made into legal ones. Even though there may be compelling reasons to prevent FAS, it may be impractical, inappropriate or unfair to adopt policies that restrict or punish women’s conduct.

I am not denying that other external factors can’t or don’t influence the choices and the range of options a person has to act otherwise. These factors explain why people drink and may become alcoholic. Nor am I suggesting that these factors may not be

good reasons for holding only the individual responsible. Even if moral responsibility can't be diminished it doesn't mean that (additional) responsibility can't be assigned to factors (or others) than that which caused a person to behave or choose in a certain way. Even though maternal drinking during pregnancy may be primarily and directly responsible for causing FAS in children, women by themselves cannot be held solely responsible.

The link between maternal drinking and FAS is contentious. Even though there is widespread consensus that prenatal exposure to alcohol can cause FAS in children, there is disagreement about a range of issues. While alcohol abuse is a known factor that increases the risk for having a FAS baby, there is no consensus about the amount and timing of prenatal alcohol exposure that can or will lead to FAS. Coupled with the uncertainty about the level of risk is the interplay of genetic and psycho-social and environmental factors. Given the uncertainties and the many variables that influence maternal drinking during pregnancy and consequently risk for having a FAS baby, a moral responsibility to stop drinking alcohol cannot firmly be grounded.

If we are to require women to practice abstinence then we should also recognise a social obligation to provide a range of interventions to assist women to avoid or, at least, reduce drinking during pregnancy. It is unreasonable, for example, to expect women particularly those who are alcoholic to simply abstain, even when they may be aware of the risks of drinking during pregnancy. It seems particularly problematic to posit an absolute obligation to refrain from alcohol, since many women may require treatment and support to overcome alcoholism and chronic drinking. Finally, it would be unfair to expect or require pregnant women to stop drinking, but not from the range of other voluntary behaviours that carry some fetal risk. Doing so would expand the

net of possible wrongdoers to include just about anyone whose actions pose risk to a fetus, but it would arguably also have the effect of paralysing women into inactivity. Despite researchers having failed so far to find any concrete evidence of fetal harm from light to moderate drinking during pregnancy, in general, we tend to frame any level of drinking as indicating serious irresponsibility on the part of the woman. Lysterly, et al (2009) argue that the widespread social anxiety of FAS “constitutes a moral panic” over pregnant women “engaging in what we imagine to be self-indulgent or decadent behavior, rather than an evidence-based response to risk” (Lysterly, et al. 2009). For them, “focusing on the consumption of alcohol as harmful a form of risk-taking seems to have more to do with images and ideologies of maternal self-sacrifice, purity and decadence than with” scientific evidence (Lysterly, et al. 2009). They point out that “pregnancy can refract and intensify the already demanding moral standards of sacrifice we apply to mothers” and “lead to a tendency to unreflectively judge *any* risk to the fetus, however small or theoretical, to trump considerations that may be of substantial importance to the woman herself” (Lysterly, et al. 2009). Thus “the widely embraced ideal of evidence-based” recommendation “is replaced with a version of the precautionary principle”, that disproportionately burdens women with the responsibility for managing reproductive risk (Lysterly, et al. 2009). Risk is always described with a value, be it the preservation of human life or respect for individual freedom. However, whenever one makes a decision, it is done in the context of conflicting, changeable scientific and technological information. Restrictions or demands should not be based on a theoretical risk without due consideration of a balanced exploration of benefits and harms. In pregnancy, the boundaries between “dangerous” and “safe” and between “reckless” and “responsible” are shaped in variable and often strict ways.

6. Do Women at Risk of Having a FAS Baby Have a Duty to Not Reproduce?

The basic idea behind a principle of parental responsibility is that prospective parents should think about the consequences for the children before embarking on parenthood. It does not demand that people cannot become parents if conditions are ideal. In terms of the principle, it would be “wrong to bring children into the world when there is good reason to think that their lives will be” miserable (Steinbock & McClamrock 1994). This means that individuals who desire to become parents may sometimes have to postpone or avoid reproduction entirely, until certain minimum conditions can be satisfied. The principle of parental responsibility implies that parents who will be or are incapable of providing their child with the minimum conditions for a decent life should avoid reproduction. At the same time the principle also implies that one should avoid reproduction if one’s child is likely to be born without a chance at a normal life. Essentially the principle holds “that prospective parents are morally obligated to consider the kinds of lives” that their children “are likely to have, and to refrain from having children if their lives will be sufficiently” miserable (Steinbock & McClamrock 1994). But what is so miserable, that it would be wrong to reproduce or bear a child?

Laura Purdy (1989) considers whether individuals “at risk of” passing on “serious disease to their” children should reproduce (Steinbock & McClamrock 1994). She argues that “individuals at high risk of transmitting” Huntington’s disease, a lethal genetic disorder, to the children, “are unable to provide them with -at least a normal opportunity for a good life and therefore should” refrain from reproduction (Steinbock & McClamrock 1994). Purdy however recognises that everyone won’t agree with her

conclusion, because not everyone shares her assessment of life with a serious disease. Huntington's chorea, in addition, is a disease that only affects people from their forties onwards; before then, they can lead relatively normal lives. She acknowledges that "Optimists argue that a child born into a family afflicted with Huntington's chorea has a reasonable chance of living a satisfactory life.... Even if it does have the illness, it will probably enjoy thirty years of healthy life before symptoms appear... Optimists can list diseased or handicapped persons who have lived fruitful lives. They can also find individuals who seem genuinely glad to be alive" (Steinbock & McClamrock 1994). A "stronger case for the moral obligation not to reproduce" is offered by John Arras (1990) who considers whether women who are infected with HIV and run the risk of transmitting the virus to their children should forgo reproduction for the sake of children (Steinbock & McClamrock 1994). Arras (1990) recognises that not all pregnant women infected with HIV will transmit the virus to their children and "that the severity of the disease varies widely", but argues that even better-off HIV-infected children have lives that are, in Arras's phrase, "decidedly grim" (Steinbock & McClamrock 1994). So, even though children infected with HIV may live somewhat satisfactory lives, the chances are good that they will live their lives under a cloud of impending death. Arras (1990) points out that in many instances, these children will also be born to parents who are themselves dying and who are therefore usually unable to care for their children. He argues that "When the medical and the social realities are considered, even an optimist should concede that it is very unlikely that an HIV-infected woman will be able to provide her baby with a reasonable (much less a normal) chance at a good life" (Steinbock & McClamrock 1994). Arras is not denying the "optimist" view, that some children may live somewhat satisfactory lives

despite having a serious disease or disability; instead he argues that these lives still fall short of a relatively normal life.

Individuals desiring to become parents base their decisions about reproduction on a myriad of factors, which should include consideration of their ability to provide a good or relatively normal life and the quality of life. Providing children with a minimally decent life requires that parents make reasonable sacrifices that entail forgoing certain pleasures and behaviours for the sake of their future children. Although “the principle of parental responsibility does not provide a formula” (Steinbock & McClamrock 1994) for making decisions about reproduction and parenthood, and because people can and do often differ on what a decent life entails, and what risks are worth taking, decisions concerning reproduction are best made by the individuals, and in particular women, themselves, since it is mostly they who will bear the burdens of childbearing and rearing.

The right to reproduce does not imply a duty to reproduce; only that people can [or should be allowed to] choose whether they wish to become parents. Because pregnancy imposes burdens on women, it should not be compelled. These burdens (or harms) are not merely that one’s body undergoes substantial change for months. In and of itself, pregnancy can impose financial, psychological, vocational and social hardships. To require women to undertake these hardships would constitute a form of involuntary servitude. Any moral or social order compelling women to undertake it unwillingly violates any claim to promoting their full social and sexual equality with men. Until a full-proof method of contraception exists, and as long as the only way for human life to develop is within women’s bodies, women need the option of abortion in order to avoid being fettered by biology. Contraception and abortion offer women the opportunities to separate sexuality from parenthood, and thus enable them to

undertake parenthood only when they feel it makes sense for their lives (Asch 1986). While pregnancy could and usually does lead to social parenthood, it need not, where women have options to avoid it.

One implication of the principle of parental responsibility as far as women are concerned is that it posits moral obligation on them to make responsible choices about pregnancy, birth and parenthood. It requires that they not harm but seek to benefit their future children by ensuring that the child will have a reasonably normal life. Thus the principle suggests that maternal drinking during pregnancy is *prima facie* wrong because it risks serious disability in one's child, and constitutes irresponsible parenting behaviour. The principle does not imply that women have duties to not reproduce or to terminate their pregnancies if their children will suffer harm or live somewhat miserable lives. It only implies that they choose wisely and take into account the kinds of lives that their children will most likely live when making decisions. It also requires that parents make fair assessments about their ability to provide for the child's basic needs to live a relatively normal life before choosing to have a child. Thus, in terms of the principle, there may be cases where the child's life will be so miserable that an abortion may be an "appropriate" and responsible "exercise of parental responsibility" (Freeman 1997:180). Deliberately conceiving a child that is likely to suffer from serious disability to live in a world that generally rejects and stigmatises disabled people seems morally reprehensible when one has the option of preventing this.

However one reason for rejecting an obligation to terminate a pregnancy for reasons of disability is because it violates the common sense notion that we should be allowed to end human life simply because it does not meet our specifications. We tend to think that, in deciding to become parents, we should be open to the possibility that we will

have children who do not meet our specifications of the “perfect” child. We may well have a child who will suffer from serious disease or disability or one who doesn’t have the physical traits we had hoped for. Even so, people generally tend to think that parents should welcome into their lives and this world, any type of child.

Ending pregnancies for reasons of disability have serious moral and social implications that go beyond an individual woman’s reproductive decisions about her own life. Terminating a human life that has already begun is not the same as pulling an infected tooth. Moreover terminating a pregnancy because of the conditions of our own lives, says something very different to terminating one’s pregnancy because we don’t like what we find out about the child (Asch 1999:387). Terminating a pregnancy because the child will be or is at risk for disability differs from a decision to end a pregnancy because one’s life has radically changed, in that it is a statement not about the woman but about the value assigned to a future child that has characteristics we don’t like. Hence, feminists such as Asch (1999) and more generally disability rights activists argue that a society that condones abortion of disabled future children communicates a message that impairment is reason enough to make life and death decisions about one’s potential value. They point out that abortion for disability-related reasons can be used as a eugenic tool and that society must consider whether it wants to send out the message to disabled people that there should be no more of their kind in future. People who are in favour of eugenic action typically believe that the quality of the human race can be improved by reducing the fertility of “undesirable” groups and at the same time, encouraging the birth rate of “desirable” groups. However, because selectively terminating the existence of seriously damaged or disabled fetuses, like abortion on the basis of sex selection, has the effect of distorting

the structure and balance of different groups in a population, it is also potentially unfair.

The principle of parental responsibility seems to imply that the only way to prevent a severely disabled or FAS child from being born is to terminate a pregnancy. In turn then it seems to follow that the woman has a general duty to submit to an abortion. But the woman also has a general right to bodily integrity – a right to choose whether to abort or not, as she prefers – thus it seems to follow that she cannot have a duty to terminate a pregnancy any more than she can have a duty not to abort a pregnancy (Feinberg, 1985:72). It is however reasonable to say that the prospective mother's duty is to take only reasonable steps to prevent harm while denying that abortion is something that can reasonably be expected or demanded of her; or perhaps we should say that the rights in question are mere *prima facie* rights, or claims of different strength, so that one type overrides the other.

Chapter 5: Social Responsibility for FAS Prevention: Should the State Punish Women for Drinking During Pregnancy?

1. Introduction

Although rational people are likely to agree that a pregnant woman who chooses to continue a pregnancy has *prima facie* moral obligations to accept certain burdens for the sake of her future child, they are equally likely to disagree about whether these moral obligations should be turned into legal ones, where failure renders her legally responsible.

Society has an undeniable “interest in the welfare of children. For example, the state has a compelling interest in securing the full citizenship capacities and rights of each of its citizens” (Brake & Millum 2014). As a society, “we have a strong collective interest in the health and welfare of our future community members” (Brake & Millum 2014), so pregnancy cannot be seen as an exclusively private matter, but also one of public concern.

Society gives parents considerable freedom in raising their children (Wikler 1978). Parents make all sorts of choices about their minor children; from what they eat and the clothes they wear to where they will go to school. Important “ends are served by relegating to parents the right to decide important issues” (Schoeman 1980) for their children. Against society, parents and their children have “rights to conditions which permit” and encourage or at least do not discourage the social and material conditions conducive to parent-child intimacy” (Schoeman 1980:9). But just how much discretion should be left to parents is not always clear. We do not always agree on how much latitude or powers parents should have over their children, hence “parental

decisions that threaten the child's chances of becoming a fully participating citizen may come under special scrutiny" (Brake & Millum 2014).

The social and economic cost of maternal drinking and consequently the range of possible conditions that could afflict a child have been described as a matter for public health. One way for states to prevent FAS is by passing legislation that criminalises and punishes drinking during pregnancy and instances of prenatal harm. The idea that women should be deterred from and punished for drinking during pregnancy and thus placing her child at risk of harm is controversial but not entirely uncommon. In the US, for example, many states have considered or implemented punitive policy in an effort to prevent prenatal harm, and which effectively infringe a woman's rights for the sake of her fetus (Armstrong 2005; Larson 1991; DeVille & Kopelman 1998; Roberts 1991; 1990; Young 1994). Some states have approached the problem of prenatal alcohol exposure by focusing on the pregnancy period; whereas others have chosen to intervene only after a child is born affected (Larson 1991). Some judges have reportedly gone so far as to sentence "pregnant addicts convicted of crimes like theft and shoplifting to much heavier sentences than they would have otherwise" (Young 1997:76). Among the policies proposed or adopted have been policies that:

- Allow for the removal of a child into (usually) state custody if a mother tests positive for alcohol or other drug use (Larson 1991).
- Allow for mandatory reporting by medical care professionals and social workers of, (even) suspected maternal alcohol or other drug use, to the state (Chavkin 1996; 1991; 1990).
- Enable others to seek a court order to compel a woman to undergo treatment (Balis 1987; Young 1994).

- Include prenatal “drug exposure in their definition of child abuse and neglect” (Young 1997).

In South Africa, although there are restrictions on the production, sale and consumption of alcohol, alcohol is widely available to, and used among, the general public. Anyone over 18 years of age can purchase and consume alcohol. However, recently there has been a proposal by the Gauteng Provincial Government to indirectly prevent pregnant women from acquiring alcohol. In terms of the draft *Gauteng Liquor Bill* (2011), a licensee (i.e. person to whom a licence has been issued and who is thereby authorised to conduct a business in terms of the Bill), may not sell, supply, or give alcohol to pregnant women. Any person who is guilty of an offence in terms of the Bill, is liable to a fine not exceeding ZAR 100 000 (one hundred thousand rand) or to imprisonment for a period not exceeding 10 years or to both such fine and imprisonment. Although the provisions are not directly aimed at pregnant women, they do ultimately operate to restrict women’s access to an otherwise legal substance for the sake of preventing FAS and its associated costs.

Punitive efforts to prevent and punish maternal drinking during pregnancy are controversial because they raise complex questions and conflicting responses. People disagree about what the role of the state should be and consequently the sorts of interventions that are appropriate responses to prevent maternal drinking and FAS. While people tend to agree about the legitimacy and appropriateness of methods that involve voluntariness e.g. voluntary health education or treatment, many may be opposed to coercive measures that criminalise and punish women for drinking during pregnancy or if her child has FAS.

The political philosopher, Alan Wertheimer (2002) points out that the question of the proper role and function of the state is a distinctly modern one. He explains that,

whereas classical western “philosophy, as exemplified by the works of Plato and Aristotle, was concerned with the nature of a good life and a good state,” and “simply assumed that a primary task of” the state was “to get its members to live moral lives” (Wertheimer 2002), early modern philosophers such as Thomas Hobbes (1968[1651]) and John Locke (1690) questioned this assumption and thus concerned themselves with the political legitimacy of or justification for the state. Nowadays, we assume, as the classical philosophers have, “that the state is legitimate, at least if it is democratic” (Wertheimer 2002). Hence our concern, today, is usually with questions about the sorts of policies that the state should adopt. Wertheimer sums up the problem for modern day political philosophy in the following way. He says that, “In liberal societies, we believe that the individual is the primary locus of moral value and that individual freedom is of the utmost importance. At the same time, we think that the state is justified in using its coercive powers to limit individual liberty if it does so for the right reasons. Unfortunately we disagree as to what those reasons are” (Wertheimer 2002:38). So, even if we agree that there are good reasons for state interference, we disagree on the extent that the state should be involved in regulating human behaviour, in other words, what sorts of policies it would be justified in implementing.

In this chapter I consider the appropriateness of punitive policies for the sake of preventing prenatal harm. I proceed by making some remarks about how we may understand the concept of “the state” and what a few thinkers have said is the proper role or function of the state. This is followed by a discussion of one the key moral justifications for state interference in individual freedom in liberal societies. Thereafter I evaluate some of the main arguments favouring punitive approaches and suggest that they are unwarranted, potentially discriminatory and likely to be

ineffective. I conclude by offering proposals for what constitutes an ethically appropriate state response to the concomitant problems of maternal drinking and FAS.

2. State, Society and Government: Defining the Concepts

A state is one of our best known institutions in society. An institution is an instance of collective action by members of a society. We do not only act as individuals; we (can) also act together with other people. In the state, we act collectively in order to protect us all against harm and to promote justice.

One definition of society is that it is an association of human beings, which includes the whole complex of the relations of man to his or her fellows, and consists of all organized and unorganized institutions and associations within the community (Appaduria, cited in Iroegbu 2013:51). By this account the state is distinct from society. Society is the bigger whole of which the state is just a part. The state is therefore created from society. And while society has no territorial limits – it can extend from a small community to the whole world – the state comprises a definite geographic region (and consequently population or society) in which it is supreme. So, unlike society, the state must have an organisation, viz., a government, that is responsible for its internal administration and its relationships with other countries. And whereas society can use moral persuasion and influence, the state is the only institution that can legitimately use force or coercion.

The authority of society mainly finds expression through customs while the state exercises its authority through laws enacted and enforced by the government. Laws that express the will of the state are framed and given effect by the government. Government is but one factor that constitutes the state, but it is the institution that holds the exclusive power to enforce certain rules of social conduct in a given

geographical area (Rand 1964). The state is therefore the principal body having original powers, while government is a subordinate agency that enjoys only delegated powers, much like those of a board of directors of a joint stock company; they are not owners of the company. Government then possesses no sovereign powers, only derivative powers delegated to it by the state through its constitution. Constitutions set out the fundamental principles and values according to which a state is governed but also act as limiters of state power by establishing the lines which individuals and collectives, including the state, cannot cross (Rand 1964). The distinction made between state and government is however mostly of theoretical value than of any practical value because all actions of the state are performed by its government and whatever the government does, it does in the name of the state. For this reason I will use the term state to include government.

3. Moral Justifications for the State

Attempts to show that the state is morally legitimate might be backward looking or forward-looking. For example for social contract theorists like Hobbes (1651[1698]) and Locke (1690), the state is justified if, and only if, every individual over which the state claims authority has consented – whether explicitly or hypothetically. Locke for instance writes that “every man, by consenting with others to make one body politic under the government, puts himself under an obligation to every one of that society to submit to the determination of the majority, and to be concluded by it, or else this original compact, whereby he with others incorporates into one society, would signify nothing, and be no compact if he be left free and under no other ties than he was in before in the state of nature” (Locke 1690:52f).

On the other hand Utilitarians of the kind espoused by, for example, Jeremy Bentham (1948) rejects the Hobbesian idea that the state is created by some kind of a social contract. Bentham for instance argues that the justification for the state can simply be found in the principle of utility, i.e. with reference to its beneficial consequences. He points out that it is the state that creates the possibility of binding contracts and that the main problem faced by the state is the question of which laws are justified.

Excepting for those who prefer anarchy, most of us would agree with the principle that the state exists to govern rights and wrongs and that one of its core purposes is protection of its members.²⁰ The state is the institution within society that is most capable of enforcing morality, but in order to effectively do so or to cultivate moral behaviour, the state must meddle in the affairs of its members. This, however, raises questions about which values a society should promote and which laws are best in achieving these ambitions.

Libertarians such as Robert Nozick (1974) argue that the only relevant wrong is coercion by the state. Thus, the state's role or obligations are limited to protecting individuals from coercion. Others however argue that the protection of individual freedom or autonomy is not the only thing that matters and that there are other considerations concerning the proper role of the state such as justice and beneficence or the promotion of social welfare. John Rawls (1971) for instance proposes that the role of the state is to create a just society.²¹ Essentially, a just society for Rawls is one where no one has an unfair advantage over others and that adopts fundamental principles of justice that would pass the following test: They must be principles that

²⁰ By anarchy I simply mean a situation where people rely purely on voluntary arrangements and there is an absence of any formal or organized system of government control.

²¹ Rawls' conception of justice is derived from the sense that Aristotle gives to justice. Aristotle interpretation of justice is that of refraining from *pleonexia*, i.e. from gaining some advantage for oneself by seizing what belongs to another, his property his reward, his office, and the like, or by denying a person that which is due to him, the fulfilment of a promise, the repayment of a debt, the showing of respect and so on.

we would rationally agree upon behind a veil of ignorance. To be behind a veil of ignorance is to know how the principles would shape society, but not to know what particular positions each of us would have in that society. On the other hand John Stuart Mill (1859) argues that the state has no business interfering in the acts and decisions of competent individuals that do not (threaten to) harm others but permits state interference where restrictions will provide benefits to others. He argues that “every one who receives the protection of society owes a return for the benefit, and the fact of living in society renders it indispensable that each should be bound to observe a certain line of conduct towards the rest. This conduct consists, first, in not injuring the interests of another; or rather certain interests, which either by express legal provision or by tacit understanding, ought to be considered as rights; and secondly, in each person bearing his share (to be fixed by some equitable principle) of the labours and sacrifices incurred for defending the society or its members from injury and molestation... [I]n all things which regard the external relations of the individual, he is *de jure* amenable to those whose interests are concerned, and if need be, to society as their protection” (1859, Ch. 1).

4. The Coercive Power of the State

This idea that the state can and should use coercion and punish wrongdoers can be traced back to the works of Thomas Aquinas for whom the “law and the” state “bear a special relationship to the use of coercion” (Anderson 2006). Aquinas argues that coercive power is not and should not be generally available to anyone to use; that it should not be vested in private parties but rather “in the whole people or in some

public personage” (Anderson 2006).²² He suggests that the law “must use force and fear in order to restrain those who are “found to be depraved, and prone to vice, and not easily amenable to words, so that they will desist from evil-doing, and leave others in peace, as well as become habituated in this way, and” thus virtuous” (Anderson 2006).

Common to all philosophical discussions of coercion is the idea that coercion involves the “use of a certain kind of power for the purpose of gaining advantages over others (including self-protection), punishing non-compliance with demands, and imposing one’s will on the will of other agents” (Anderson 2006). In some ways, many modern philosophers’ such as Thomas Hobbes 1968[1651]), John Locke (1690), Immanuel Kant (Kant 1996 [1797]) and John Stuart Mill (1859) hold views on coercion follow that of Thomas Aquinas (Anderson 2006).

Although Hobbes, Locke and Kant “differ in innumerable ways in their philosophical and ethical views, they appear to hold similar views of the nature of coercion and its role in the function of justice and the state” (Anderson 2006). All seem to agree that “coercion is essential to both the justification of and function of the state” (Anderson 2006); that it is necessary “for people to establish a state with coercive powers in order to achieve justice” (Anderson 2006). Hobbes, for example, sees the state’s coercive power as necessary for ensuring performance of obligations by parties to a contract (Hobbes 1968[1651]: Ch. 14). Similarly, Locke (1690) believes “that the function of the state is intimately tied to its role in securing individuals against those who would” harm them (Anderson 2006). Although Kant differs in his views on the necessity of coercion from those of Hobbes and Locke, he supports the idea that states

²² Aquinas does however allow some parties which he refers to as “imperfect communities” such as the head of a household, to” be able to use an “imperfect coercive power, which is exercised by inflicting lesser punishments, for instance by blows, which do not inflict irreparable harm” (Anderson 2006).

“require the ability to use coercion in defense of the equal freedom of their” citizens (Anderson 2006). Kant thinks that “there are two sorts of incentives to follow the law: ethical and juridical” (Anderson 2006). For Kant, “the ethical” or “rational incentive to” obey “the law is the motive of duty” (Anderson 2006). However, he recognises that some people’s will is determined “by inclinations and aversions, rather than by duty” (Anderson 2006). Thus he holds that there also needs “to be a way to get such persons to follow the law as well, through such means as aversion to punishment” (Anderson 2006). “Coercion is then a tool the law uses to get the lawless to respect the rights of others whether they want to or not” (Anderson 2006). “Kant makes clear that coercion counts as a hindrance to freedom, in which respect it is similar to all violations of a person’s rights, but” that “coercion can” also “be used to prevent other rights violations, and thus may be justified on the grounds that it counts as a hindrance to freedom” (Anderson 2006).

John Stuart Mill also “associates coercion with the state’s powers to punish lawbreakers” (Anderson 2006). However, “he takes a more expansive view of what coercion amounts to than” do those of Kant, Locke and Hobbes. Mill seems to “treat the terms coercion and interference as much the same thing” (Anderson 2006). In *On Liberty*, he says that “the object of this essay is to assert one very simple principle, as entitled to govern absolutely the dealings of society with the individual in the way of compulsion and control, whether the means used be physical force in the form of legal penalties, or the moral coercion of public opinion. That principle is that the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection... [An individual] cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would

be wise, or even right. These are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not for compelling him, or visiting him with any evil in case he do otherwise” (Anderson 2006).

“In treating coercion expansively” Mill captures “a number of different ways in which powerful agents could exercise constraining power on others besides the use of force, violence, and threats thereof” (Anderson 2006). He “suggests that the potency of legal penalties often resides more in the stigma they attach than the actual punishments they apply” (Anderson 2006). Thus he says that the “chief mischief of the legal penalties is that they strengthen the social stigma. It is that stigma which is really effective.... Our merely social intolerance kills no one, roots out no opinions, but induces men to disguise them, or to abstain from any active effort for their diffusion” (Anderson 2006). In contrast to earlier thinkers Mill recognises “that the power of civil institutions is frequently on par with the power of the state, and treats the potential for coercion by these other institutions as similarly a matter of concern” (Anderson 2006).

5. Justification for State Coercion

Coercion (sometimes also described as compulsion) “is typically thought to carry with it several important implications, including that it diminishes” a person’s “freedom and responsibility and is a” *prima facie* “wrong and/or violation of individual rights” (Anderson 2006). However, “few believe that” coercion “is always unjustified” or wrong, “since no society can” effectively “function without some” authorised “uses of coercion” (Anderson 2006). Because of its usefulness (e.g. maintenance of social order, the achievement of justice) and its sometimes devastating effects, coercion remains both politically and ethically controversial.

To some extent, all state policies involve interfering with people's freedom to act as they please. The paradigmatic case of state interference with individual freedom involves the use of criminal law to either forbid people to behave in certain ways (e.g. from committing murder or theft) or to require us to behave in certain ways (e.g. pay state taxes and wear seatbelts). Law is by nature coercive because it aims to regulate human behaviour and to punish offenders. However, to say that law infringes individual freedom is not to say that coercion *per se* is problematic. Often there are good normative reasons for the use of state coercion.

5.1. Harm Principle

John Stuart Mill (1859), proposed what is possibly the most widely cited justification for interference by a liberal state in individual freedom. In his seminal essay, *On Liberty*, Mill argues “that the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, self-protection. The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others... his own good, either physical or moral, is not a sufficient warrant. He cannot rightly be compelled to do or forbear because it will be better for him to do so, or because it will make him happier, or because in the opinion of others, to do so would be wise, or even right.... [While these are] good reasons for remonstrating with him or reasoning with him, they are not good reasons for compelling him, or visiting him any evil. To justify that, the conduct from which it is desired to deter him must be calculated to produce evil to someone else. The only part of the conduct of anyone for which he is amenable to society is that which concerns others. In the part which merely concerns himself, over his mind, over his own body and mind, the individual is sovereign.... If

anyone does an act hurtful to others, there is a *prima facie* case for punishing him by law, or where legal penalties are not safely applicable, by general disapprobation.... Whenever... there is definite damage, or a definite risk of damage either to an individual or to the public, the case is taken out of the province of liberty and placed in that of morality or law” (Mill 1859: Ch. 1).

Mill makes clear that the principle applies only to “human beings in the maturity of their faculties” in “a civilized community” (Mill 1859: Ch. 1), thus leaving open the possibility for legitimate interference in the lives of those incapable of fully making free choices e.g. children and mentally disabled people.

Mill explains that an action is harmful to others if it is “injurious or sets back important interests of particular people; interests in which they have rights”, without “their free, voluntary, and undeceived consent and participation” (Mill 1859, Ch. 1). “To satisfy the harm principle, an action need not cause harm; it is enough if it poses a substantial risk of imminent harm” (Mill 1859, Ch. 4). According to Mill, we can harm others through both our acts and our omissions, but “a much more cautious exercise of compulsion” is required in the case of our inactions. He says that that to make anyone “answerable for not preventing evil, is comparatively speaking, the exception” (Mill 1859: Ch.1). For Mill, “inaction constitutes harm only when it is obviously a man’s duty to act” (Mill 1859: Ch. 4). Thus, whether a person’s omissions harm another will depend on whether he or she had a duty to act.

The principle espoused by Mill is widely known as the harm principle. In terms of the principle, a liberal state and others have no business interfering in a person’s freedom when his or her actions affects the interests of no other person but the actor self. Interference in individual freedom is therefore justified only if it aims to prevent (risk of) harm to others. Where the individual’s actions affect only the actor, then

interference is not justified by the principle. In terms of the principle there can be no victimless crimes, and one cannot commit a crime against oneself. If an action has no victim, i.e. someone other who will be harmed, and if one has freely consented to the risk of harm, then there cannot be a wrong, in the sense that it justifies interference in individual freedom of action.

In terms of this principle punishing someone for failing to prevent harm to others should not be the norm and occur only in exceptional cases. This suggests that a distinction be made between cases where someone intentionally causes harm from cases where someone fails to take steps to prevent harm from materialising. As has been previously shown in this dissertation, it is easier to argue that we have a (negative) duty not to harm others than it is to argue that we have (positive) duties to help them. Thus we may for example judge more seriously a person who intentionally drowns another person, than the one who failed to attempt a rescue. In the former case the individual is clearly harmed by the action, however, in the latter case, it is not obvious that the person was harmed (in the sense that he or she is wronged) by the inaction.

Mill does not seemingly specify who those others are, whom it would be wrong to harm. If “others” refer only to persons, and if the fetus is a person, then it would be *prima facie* wrong to harm it in the same way that harming an adult person is. However, if the fetus is not a person, then the harm principle may not support restrictions on a woman’s conduct for the sake of her fetus. Whether the fetus qualifies as such a being is ethically contentious. Thus the application of the harm principle requires consensus on the status of the fetus.

Although Mill argues that causing harm is generally always a wrong, he maintains that regulation may not always, on balance, be best (Mill 1859: Ch. 1). So, while he

recognises that there may be good reasons for holding individuals accountable for their harmful acts, he, at the same time believes that there sometimes may be more compelling reasons for us not to do so. According to him, this would be the case where the interference will “produce other evils, greater than those which it would prevent” (Mill 1859: Ch. 1). He goes on to say that, “When such reasons as these preclude the enforcement of responsibility, the conscience of the agent himself should step into the vacant judgment-seat, and protect those interests of others which have no external protection” (Mill 1859, Ch. 1). Thus by Mill’s account an evaluation of policy that interferes with individual freedom requires that two approaches be taken. First it must be evaluated from a philosophical perspective in terms of moral justification to determine whether it is justified by ethical principles. Secondly, it must be evaluated from the perspective of efficacy, to determine if it will, on balance, be more beneficial than harmful.

6. Problems with Punitive Approaches

Punitive measures are troubling because they involve intrusions and restrictions of varying duration, degree and risk in a person’s freedom and rights. Punitive approaches that criminalise and punish drinking during pregnancy allow for women to be arrested and charged criminally and if found guilty, to receive a sentence as punishment. Proponents of punitive approaches argue that the rights of pregnant women may or should be curtailed in some circumstances, either because they believe that the fetus has rights or because of the consequences of permitting women to do entirely as they wish. Proponents of criminal approaches further point out that the harm to the woman is minor compared with the benefits to her child and society. HLA Hart for instance argues that a law penalising prenatal culpable conduct is desirable

because “it announces to society that these actions are not to be done and to secure that fewer of them are done” (Hart 1968:6), whereas Sam Balisy (1987) argues that the cost of caring for drug-damaged children and the state interest in protecting fetal life are good reasons for imposing criminal sanctions, including compelled enrolment in rehabilitation programmes.

The mere fact that a policy involves coercion does not imply that it is unjustified. In liberal societies, the harm principle is one of the most widely cited justifications for state interference in an individual’s freedom or rights. But even if a policy criminalising drinking during pregnancy may be defensible, it suffers from serious problems and shortcomings, which suggests that it will be largely ineffective at achieving its supposed ends of protecting fetuses and future children from harm. There are several reasons that warrant concern about the use of punitive state policy to prevent FAS; some of which I now turn to.

6.1. Uncertainty Principle

The uncertainty principle implies that we cannot punish someone for a harm that has not yet occurred and which may not occur. Although FAS is preventable, much of the “data on the problem remain unequivocal and are rendered problematic by several confounding factors. Polydrug and multiple substance use may make it difficult for investigators to determine both the amount of the substance or substances ingested and when in the course of the pregnancy they were used. Other factors, such as socioeconomic status, the availability of prenatal care and individual patient pathophysiology, frequently have an important role in suboptimal fetal outcomes” (DeVille & Kopelman 1998).

Not all women who drink alcohol will have a FAS baby. We cannot predict which fetuses and future children will be seriously harmed as a consequence of maternal drinking. There is for example, uncertainty about the precise amount and pattern of prenatal alcohol exposure and the conditions which result in FAS. A myriad of psycho-social and economic factors coupled with maternal characteristics have been found to increase the risk of drinking during pregnancy and having a FAS baby. The problem of accurately predicting or knowing the precise conditions that cause FAS is compounded by maternal polydrug use, since it will be harder to isolate the exact harm-causing agent.

Punitive measures therefore fails to take into account the fact that there are complex interactions between genes, the environment and pattern and extent of prenatal alcohol exposure that shape birth outcomes. They are therefore at odds with scientific evidence that suggests that a complex relationship exists between alcohol and pregnancy outcomes. Moreover, we do not ordinarily punish people for what they might do but rather for what they factually do. For example, we know that driving a motor vehicle is a potentially dangerous activity to others (e.g. pedestrians) but we do not ban driving on the basis that it might harm others.

6.2. Potentially Unfair and Discriminatory

Punitive approaches that single out women and more specifically, pregnant women for punishment is potentially unfair and discriminatory, hence contrary to the common dictates of justice. It would be unfair to single out prenatal alcohol exposure through maternal drinking for punishment, when many other harmful substances and behaviours are not punishable. For example we might inquire about the father's

drinking habits (Gearing, McNeill & Lozier 2005; Hye Jeong, et al. 2013)²³ or woman's family life, since these have also been found to impact fetal health. Moreover, since it is not ordinarily permitted to require substance abusing non-criminals to enter treatment or rehabilitation programmes, it is "reasonable to assert that there must be a compelling state interest to warrant a change in the rules with regard to pregnant women" (Mathieu 1991).

Iris Young (1994) and Dorothy Roberts (1990) point out that the targeting of women drug users for particular surveillance and policies raise questions not only about sexism but also racism implicit in such policies. Where they have been imposed, "criminal sanctions against pregnant women" have typically been "applied unequally", resulting in mostly poor black "women bearing the brunt of suspicion and prosecution" (Armstrong 2005). To avoid charges of unfair discrimination, punitive sanctions would have to extend equally to any other person whose behaviour is harmful to the fetus and future child.

6.3. Consequences for Medical Professionals' Relationships with Patients and Patients' Access to Health Care

The threat of criminal punishment will foster a climate of fear and mistrust between medical professionals and patients, thus placing the health of both woman and child at greater risk (Hackler 2011). "If women perceive that health care is entangled with the criminal justice system", they are likely to avoid seeking prenatal care (Armstrong 2005, Hackler 2011).

Early identification and intervention can assist affected children so that they may lead relatively normal lives however a particular concern about criminal approaches relates

²³ Paternal alcohol use has for example been found to alter a man's sperm (Bielawski & Abel 1997; Strickland 1996) and impact infant birth weight (Little & Sing 1987).

to its reliance on the identification and reporting of women who either are at risk for having a FAS baby or who have already given birth to a FAS baby. In a sense it presupposes the involvement of medical professionals, and places them in a policing role, which may have detrimental effects on their relationships with patients (DeVille & Kopelman 1998; Larson 1991; Mulvey, et al. 1987).

Medical professionals might lose their treatment function and instead degenerate into social monitoring functions if they have to screen, identify and report pregnant women who use alcohol (Mulvey, et al. 1987). Mandatory screening and testing of children, even for their own sake will, additionally, have the effect of inadvertently exposing mothers who drank during pregnancy, hence compromises her right to privacy (Young, et al. 2009). Compulsory screening and testing implies that the doctrine of informed, voluntary consent, which applies to all competent patients, can be encroached in the case of alcohol-abusing pregnant women (Arrigo 1992; Chavkin 1992; Mulvey, et al. 1987). Furthermore, there is little point in identifying women and children at risk if they do not have access to appropriate treatment and support services. A study by Skolnick (1990), found that “care provided in the framework of support, rather than judgment, can improve the outcome for drug-abusing pregnant women” (Young 1997:174-175). In this study, over 80% of pregnant addicts who tested positive for drug use agreed to counselling and a little over 60% of those in counselling discontinued their drug use (Skolnick 1990; Young 1994; 1997). Because women who abuse alcohol and other substances are most at risk for having a child with FAS, it is crucial that prenatal care and other services are accessible to them in a supportive environment, so that the potentially harmful effects on pregnancy outcomes can be minimised, if not avoided.

6.4. Ineffective

Underlying punitive approaches to prevent FAS, is the idea that women who are alcoholic will weigh the benefits of drinking against the costs of doing so (i.e. punishment) and will choose abstinence. But this is unreasonable because it assumes that it is entirely within her control to choose not to drink, “if she judges the costs to be too high” (Young 1994). It ignores the concept of alcoholism, which “implies a limitation on the free agency and thus responsibility of the woman” (Young 1994).

There are paternalistic dangers in promoting a model of alcoholism that depicts the habitual drinker as completely irrational, unaware, or out of control. But there are equal dangers in denying the reality of alcohol dependence that is so ingrained in a person’s habits, their way of life and desires that make them somehow not responsible for their continuing use.

Few people, if any, use drugs with the aim of becoming dependent or addicted. Many people believe that they can control their use and thus avoid addiction. And even when they may have a problem, they may refuse to admit to it. And even if they admit to it and desire abstinence, they may find it very hard to stop. So, even when medical recommendations during pregnancy are clear and definite some women may still have difficulty following them. There is little reason to think that they will be any different from the drunk driver who, despite its unlawful status and the risks involved, continues to drink and drive (Abel 1998). What Abel (1998) is suggesting is that punitive measures may be ineffective because the pregnant alcoholic woman is essentially an “alcoholic who is pregnant, rather than a pregnant woman who happens to become alcoholic during pregnancy”.

Although policymakers and legislators “may be motivated by an understandable desire to protect children”, but criminalising the woman’s conduct will not accomplish that goal (Armstrong 2005). As Elizabeth Armstrong correctly notes, punishing women “may feed a sense of social retribution” but it will neither prevent harm nor promote child welfare (Armstrong 2005). Women will be identified and punished long after prenatal harm may already have been done. Moreover, sentencing women to imprisonment will have the unintended effect of placing woman and child at additional and increased risk because they are likely to be exposed to violence, infectious diseases and other potentially stressful conditions.

Providing treatment programmes on a voluntary basis and encouraging women to participate in them is a reasonable alternative to coercion because voluntary programmes can have the same outcomes with the use of less intrusive methods. Research suggests that “coerced patients often do as well as patients who have sought treatment voluntarily” (Mark 1988; Westermeyer 1989).

6.5. The Status of the Fetus

A final and significant reason for thinking that punitive approaches are inappropriate means to prevent FAS pertains to the ethically controversial status of the fetus. Punitive approaches imply that the fetus is a physically separate entity to that of its mother. However because of its unique situation, it is unlike a born child. It cannot be removed from the care of its alcohol abusing mother and it cannot be protected from harm in the same way that a born child can be. For the state to protect fetuses and future children from harm it will literally have to invade the woman’s body.

Currently in South Africa a fetus acquires legal personality, hence legal personhood only upon live birth. Given this reality, the state would be hard pressed to show why

any rights and interests of or obligations to a fetus – which effectively is a non-legal person – should take precedence over those of a live born person.

Punitive approaches “run counter to the dictates of medical care, public health and rights” (Armstrong 2005). They fail to respect a woman’s rights to autonomy and bodily integrity and their status as citizens entitled to equal treatment and protection under the law. In addition their implementation and enforcement will require new or additional resources to be made available; something most societies can ill afford. Given the possible ineffectiveness and costs involved in punitive approaches, it seems irrational to adopt policies that seek to criminalise or punish woman’s conduct during pregnancy. An ethically appropriate and effective response to FAS prevention requires a coordinated multifaceted approach that does not penalise, but rather aims to assist women and children, through the provision of education, health care and access to treatment and support services. By integrating efforts within existing programmes, limited resources can be used more efficiently, thereby providing additional public health benefits.

7. Effective Approaches to Prevent Maternal Drinking During Pregnancy and Consequently FAS

Young, et al. (2009) identify four major periods when the state has an opportunity to intervene to prevent maternal drinking during pregnancy and consequently FAS. According to these writers, the state can intervene during the pre-pregnancy stage, during pregnancy, at birth and after birth. At the pre-pregnancy stage the state can

implement strategies such as placing warning labels on alcoholic beverages²⁴, providing educational materials and conducting awareness campaigns on the effects of alcohol use during pregnancy. Pregnant women can be screened for alcohol use using validated tools such as the T-ACE and the TWEAK (Bradley, et al. 1998; CDC 2009; Chang 2001), as part of routine care and those at risk be referred to treatment and related services. Young, et al. (2009), further insist that to reduce the risk for maternal drinking during pregnancy and FAS, and thus improve the “chances for a healthy birth outcome, there must be an effective link between screening and facilitating a woman’s access to necessary treatment and related support services” (Young, et al. 2009:25). Interventions that can be offered at or post-birth, include the early identification of or diagnoses of children so that mother and child can be connected to adequate treatment services (Young, et al. 2009). These services must, however, cater for the particular needs of women and children if they are to be successful (Armstrong 2005; Ashley, et al. 2003; Streissguth, et al. 2004).

7.1. Effective Interventions for Alcoholism

Dependence on alcohol and/or other drugs may impede an alcoholic’s efforts to abstain from alcohol. Alcohol dependence (or alcoholism as it is commonly known) is a clinical diagnosis that is regarded as distinct from the harmful use of alcohol.

Multiple interacting factors – genetic, psycho-social and economic – increase an individual’s risk for alcoholism. Even if women alcoholics may have some sense of control over their decisions about drinking, a range of variables influence their risk for having a child with FAS. At the same time, we must acknowledge that alcoholism

²⁴ Health warning labels have been shown to “raise awareness and reduce alcohol intake among light to moderate drinkers” (Fenaughty & MacKinnon 1993). In South Africa manufacturers of alcoholic beverages are legally required to place warning labels on their products in terms of the *Regulations to the Foodstuffs, Cosmetics and Disinfectants Act* (1972).

involves a biochemical process, where the alcoholic is seen as physiologically dependent, and often unable to (simply) quit without assistance. Wilson and Wilson (2013) identify the following approaches as among the most effective interventions to manage alcoholism as including a combination of strategies that can be offered as part of routine medical assessment. These are “brief interventions, motivational interviewing, social skills training, community reinforcement, self-change manuals, behavioural self- control training and pharmacology” (Wilson & Wilson 2013).

Brief interventions have been shown to be effective in reducing alcohol use among women who drink and are not effective birth control (Bient, et al. 1993; Wilk, et al. 1997; Whitlock, et al. 2004). Brief interventions are structured and time-limited (usually about 15 minutes) interventions, which aim to educate patients about alcohol use, screen drinking behaviour and detect problems and individuals at risk so that appropriate interventions can be made early.

Motivational enhancement therapy (interviewing) is an evidence-based psychotherapeutic method that involves counselling aimed at creating awareness of the consequences of drinking and helping a person to think about making a change to their current circumstances, and to “identify potential change strategies and choose the most appropriate course of action” (Wilson & Wilson 2013).

Community reinforcement approaches aim to achieve abstinence. Several “components are integrated in this approach – learning new coping behaviours, particularly those involving interpersonal communication, involving the family, work and social environment in the recovery process” (Wilson & Wilson 2013).

“Social skills training is a treatment method that aims to discourage addictive behaviour, by showing the individual how to meet the demands of life without the use of substances” (Wilson & Wilson 2013). This relies on programmes that provide

people with, among other things, “training in anxiety management, problem solving skills, and job skills” (Wilson & Wilson 2013).

Treatment and support services may be effective in both reducing the risk of prenatal alcohol exposure or its effects (Marwick 1989; Quinlivan & Evans 2005). However, many women have inadequate access to treatment and many may not seek treatment, promptly, if at all, for a host of reasons that have largely to do with their socio-economic circumstances. For example, women in abusive relationships may fear possible repercussions; others may avoid seeking help because they fear stigmatisation and many may not because services are remote far or too costly to access.

8. South African Policies Relevant to the Prevention of and Treatment for Substance Abuse

A few policy documents contain the South African government’s response to drinking during pregnancy and FAS. This includes the *Prevention of and Treatment for Substance Abuse Act* (No. 70 of 2008), the National Drug Master Plan (Department of Social Development 2007), the National Human Genetics Policy Guidelines for the Management and Prevention of Genetic Disorders, Birth Defects and Disabilities (Department of Health 2001) and the Guidelines for Maternity Care in South Africa (Department of Health 2002).

The *Prevention of and Treatment for Substance Abuse Act* (No. 70 of 2008) is the primary piece of legislation governing the prevention of and treatment for substance abuse in South Africa. Four central aims of the Act are “to provide for a comprehensive national response for combating substance abuse; mechanisms aimed at demand and harm reduction in relation to substance abuse through prevention, early

intervention, treatment and re-integration programmes; the committal of persons to and from treatment centres and for their treatment, rehabilitation and skills development in such treatment centres” and “to provide for the establishment of the Central Drug Authority”²⁵ (section 2). For purposes of the Act the terms abuse substances, drugs and treatment are defined as follows. “Abuse means the sustained or sporadic excessive use of substances and includes any use of illicit substances and the unlawful use of substances” (section 1). “Substances mean chemical, psychoactive substances that are prone to be abused, including tobacco, alcohol, over the counter drugs, prescription drugs and substances defined in the *Drugs and Drug Trafficking Act* (No. 140 of 1992), or prescribed by the Minister” of Social Development “after consultation with the Medicines Control Council” (section 1). For purposes of the Act the term drugs has a similar meaning to that of substances (section 1). The Act defines treatment as “the provision of specialised social, psychological and medical services to service users and to persons affected by substance abuse with a view to addressing the social and health consequences associated therewith” (section 1).

The Act obligates the Minister of Social Development together with other government departments and organs of state, to “take reasonable measures, within the scope of their line functions and available resources, to combat substance abuse through the development and coordination of interventions that fall into three broad categories, namely -:

- (a) Demand reduction, which is concerned with services aimed at discouraging the abuse of substances by members of the public,

²⁵ Major functions of the CDA include: advising the Minister of Social Development on matters pertaining to alcohol and drug abuse; developing a “National Drug Master Plan as a national strategy for managing the demand for and supply of illegal drugs in the country, and for facilitating an integrated approach to service delivery and the coordination of programmes on the management of the drug problem in all spheres of government and civil society” (Rendall-Mkosi, et al. 2008).

- (b) Harm reduction, which for purposes of the Act is limited to the holistic treatment of service users and their families, and mitigating the social, psychological and health impact of substance abuse, and
- (c) Supply reduction, which refers to efforts aimed at stopping the production and distribution of illicit substances and associated crimes through law enforcement strategies as provided for in the applicable laws” (section 3).

Together with these specified groups, the Minister of Social Development must “develop and implement comprehensive intersectoral strategies aimed at reducing the demand and harm caused by substance abuse. These strategies must include four categories of services, namely” prevention programmes, early identification programmes, treatment and rehabilitation programmes and aftercare and reintegration services (section 5).

8.1. Prevention Programmes

Prevention programmes aim “to prevent a person from using or continuing to use substances that may lead to abuse or result in dependence” and “provides for-

- (i) measures aimed at skills development for individuals, families and communities to enable them to enjoy a better quality of life;
- (ii) anticipatory actions to reduce the likelihood of undesirable conditions which may expose people to substance abuse, including information, communication and education of members of the public about the risks associated with substance abuse;
- (iii) proactive measures targeting individuals, families and communities to avoid the abuse of substances and to prevent persons from moving into higher levels of substance abuse; and
- (iv) the creation of opportunities for and promotion of healthy lifestyles” (section 5).

8.2. Early Intervention Programmes

Early intervention programmes aim “to identify and treat potentially harmful substance use prior to the onset of overt symptoms associated with dependency” on substance, and provides for:

- (i) the identification of risky behaviour that is associated with and predisposes people to substance abuse;
- (ii) the detection of conditions such as poverty and other environmental factors that contribute to crime and the abuse of substances;
- (iii) diversion of service users to programmes that promote alternative lifestyles;
- (iv) programmes to interrupt progression of the abuse of substances, such as recreational drug use, to the higher levels of dependence through skills development and developmental socio-therapeutic interventions; and
- (v) referral to treatment programmes, where appropriate, to reduce the social, health and economic consequences for service users” (section 5).

The Act obligates the Minister to “facilitate the establishment of community-based services with special emphasis on under-serviced areas” (section 13). The Act defines “community based services as services provided to persons who abuse or are dependent on substances and to persons affected by substance abuse while remaining within their families and communities” (section 1). In terms of the Act, “community-based services must:

- (i) include community-based treatment programmes;

- (ii) establish or utilise existing facilities and infrastructure, including primary health care centres to provide integrated community based treatment programmes;
- (iii) consist of a multidisciplinary team consisting of a social worker, professional nurse and any other mental health practitioner registered with the relevant statutory body;
- (iv) provide professional and lay support within the home environment;
- (v) establish recreational, cultural and sports activities to divert young people from substance abuse; and
- (vi) provide for support groups for service users and those affected by substance abuse” (section 13).

8.3. Treatment and Rehabilitation Programmes

In terms of the Act, treatment and rehabilitation programmes include:

- “(i) medical interventions that address the physiological and psychiatric needs of the service user;
- (ii) psycho-social programmes that address the relationships, emotions, feelings, attitudes, beliefs, thoughts and behaviour patterns of service users;
- (iii) provision of interventions that target the environmental factors in the space of the service user, including the family and community; and
- (iv) the preparation of service users for reintegration into society through developmental programmes, including skills development; and after care and reintegration services” (section 5).

The Act further requires that the Minister, in consultation with others, “establish, maintain and manage at least one public treatment centre” that offers in-patient and

out-patient treatment,²⁶ in each of South Africa's nine provinces "for the reception, treatment, rehabilitation²⁷ and skills development of users" (section 17). The Act furthermore obligates the Minister to establish, maintain and manage halfway homes, which may be private or public, "to provide a sober living environment for service users who have completed a formal treatment programme for substance abuse and require a protected living environment in order to prepare them for reintegration into society" (section 1).

In terms of the Act, a person may be admitted voluntarily or involuntarily to a treatment centre. An admission is voluntary when a person or any other person acting on that person's behalf applies for admission to a treatment centre (section 32). An involuntary user is someone "who has been admitted to a treatment centre upon being convicted of an offence and has in addition or in lieu of any sentence in respect of such offence been committed to a treatment centre or community based treatment service by a court; committed to an in-patient treatment centre by way of a court order after such court has held an enquiry; or transferred from a prison, child and youth care centre, alternative care or health establishment, for treatment of and rehabilitation for substances" (section 1).

In terms of the Act, a voluntary service user "is entitled to appropriate treatment, rehabilitation and skills development services" (section 32). The Act obligates the Department of Health to "provide detoxification services and health care requirements" to those using public health establishments (section 32). Detoxification

²⁶ The Act defines "in-patient service" as meaning "a residential treatment service provided at a treatment centre" and "out-patient as meaning a non-residential service provided by a treatment centre or halfway house to persons who abuse substances and to persons affected by substance abuse and which is managed for the purposes of providing a holistic treatment service" (section 1).

²⁷ Rehabilitation is defined in the Act as "a process by which a service user is enabled to reach and maintain his or her own optimal physical, psychological, intellectual, mental, psychiatric or social functional levels, and includes measures to restore functions or compensate for the loss or absence of a function" (section 1).

is defined in the Act as “a medically supervised process by which physical withdrawal from a substance is managed through administration of individually prescribed medicines by a medical practitioner in a health establishment, including a treatment centre authorised to provide such a service under the *National Health Act*” (section 1).

Generally, “an involuntary service user, may not be provided with treatment, rehabilitation and skills development at a treatment centre unless a sworn statement is submitted to a public prosecutor by a social worker, community leader or person closely associated with such a person, alleging that the involuntary service user is within the area of jurisdiction of the magistrate’s court to which such prosecutor is attached and is a person who is dependent on substances and—

- (i) is a danger to himself or herself or to the immediate environment or causes a major public health risk;
- (ii) in any other manner does harm to his or her own welfare or the welfare of his or her family and others; or
- (iii) commits a criminal act to sustain his or her dependence on substances” (section 33).

In terms of the Act, a “court convicting a person of any offence may in addition or in lieu of any sentence in respect of such offence order that such person be committed to a treatment centre” (section 36). However, “such an order may not be made in addition to any sentence of imprisonment, whether direct or as an alternative to a fine, unless the operation of the whole sentence is suspended” (section 36).

8.4. Aftercare and Reintegration Services

Aftercare and reintegration services aim to successfully reintegrate a “service user into society, the workforce and family and community life” (section 5). The Act defines aftercare as meaning ongoing “professional support to a service user after a formal treatment episode has ended in order to enable him or her to maintain sobriety or abstinence, personal growth and to enhance self-reliance and proper social functioning” (section 1). In terms of the Act, aftercare and reintegration programmes must “provide for -

- (i) integration of people who have undergone the formal treatment episode into their families and communities;
- (ii) individuals to be equipped with additional skills to maintain their treatment gains, sobriety and avoid relapse;
- (iii) establishment of mutual support groups to enhance their self-reliance and optimal social functioning; and
- (iv) link between service users and resources for their further development and well-being” (section 5).

The Act encourages the establishment of support groups, “at community level by a professional, non-governmental organisation or a group of service users or persons affected by substances abuse, that focus on integrated ongoing support to service users in their recovery” (section 31).

In keeping with the provisions of the *Prevention of and Treatment for Substance Abuse Act*, the National Drug Master Plan (NDMP) aims to bring about the reduction of substance abuse and its related harmful consequences, and recognises that in order to do this effectively, there must be a balance between actions, which bring about a decrease in the availability of drugs (through control and enforcement), and, the

demand for drugs (through prevention, treatment and rehabilitation) (Department of Social Development 2007). “It outlines the role that each department should play in fighting abuse” (Rendall-Mkosi, et al. 2008), particularly among young women of reproductive age, and mentions teenage pregnancy, FAS, STIs and HIV/AIDS as areas of special concern.

A central aim of the of the *Prevention of and Treatment for Substance Abuse Act* (2008) and the NDMP, is to ensure access to services for those most directly affected by substance abuse, however, treatment facilities typically situated only in major metropolitan areas and none appear to provide services for specifically pregnant who abuse alcohol or other drugs (Ovens 2009). A report issued by the Alcohol and Drug Abuse Research Unit found treatment services to be particularly inaccessible for young, poor and black South Africans and recommended that the existing treatment services “revise their admission criteria to ensure that” they are accessible to black clients (Alcohol and Drug Abuse Research Unit 2005). The report further recommends “an increase in state funding for services to allow for the treatment” of indigent persons (Alcohol and Drug Abuse Research Unit 2005).

9. South African Policies Relevant to the Prevention FAS

In accordance with the *Guidelines for Maternity Care in South Africa*, the use of maternal alcohol, tobacco and other substances should be explored as part of history taking (Department of Health 2002). Other than the NDMP, the *Human Genetics Policy Guidelines for the Management and Prevention of Genetic Disorders and Birth Defects* (Department of Health 2001) appears to be the only other policy document that specifically mentions FAS as a national priority condition (Rendall-Mkosi, et al. 2008). The “guidelines list the following three key interventions for FAS:

- Educate all women regarding the deleterious effects of alcohol on the fetus,
- Educate all women to avoid alcohol throughout pregnancy,
- Offer early detection of FAS, with appropriate referral of affected individuals and their parents for counseling and care” (Rendall-Mkosi, et al. 2008).

The public policy documents discussed contain mechanisms that could have a significant impact on the harmful use of alcohol in South Africa. However, their level of success in meeting their objectives is hampered by a shortage of resources – financial or otherwise (Parry & Bennetts 1998). Moreover, when compared to some of the country’s other pressing problems e.g. crime, unemployment and HIV/AIDS, the harmful use of alcohol can appear almost secondary. Parry and Bennetts (1998) note that budgets for alcohol and drug abuse are typically included in broader categories such as welfare. There is little value in identifying women at risk, if we do not provide them with support services to assist them to abstain. By integrating prevention efforts within existing programmes, limited resources can be used more efficiently, thereby providing additional public health benefits.

10. Concluding Remarks

This chapter sought to consider and evaluate punitive measures to prevent FAS. One way for the state to prevent FAS is by criminalising and punishing maternal drinking during pregnancy. However underlying such policy is an unrealistic expectation that women should do just about everything that they can that will benefit and not harm their fetuses. Punishing women for alcohol use during pregnancy would open the door to the placement of restrictions on a range of behaviours during and possibly even prior to pregnancy that could have the effect of paralysing them into inactivity and treating them as no more than fetal containers.

Other reasons for opposing punitive measures relate to the uncertainty principle, the potential for discrimination and relative ineffectiveness of such measures.

Efforts to prevent maternal drinking and consequently protect future children from harm must seek to safeguard a woman's health and well-being, as well as her autonomy and dignity. It must also recognize the myriad of factors that place a woman at risk for drinking during pregnancy and consequently having a FAS baby. Effective FAS prevention will thus require a coordinated interdisciplinary response that involves a range of interventions aimed at women, children and wider society. Interventions must address each of the determinants and risk factors that create and facilitate risk for maternal drinking during pregnancy. This includes access to adequate treatment for women at risk or who may be alcoholic, so that have a chance at abstinence or moderating alcohol use. As Elizabeth Armstrong (1005:46) correctly notes, "If we truly care about improving and protecting children's well-being, we need to first care about women; whether they are mothers or not".

In addition, sexually active women who drink and may not be using contraception may find themselves pregnant unintentionally. Therefore we "need to continue to focus on the goals to reduce unintended pregnancy in all women, through the provision of safe and effective contraception, empowering women in their relations with men and ensuring access to safe and legal abortion so that women who experience an unwanted pregnancy are not faced with the unwelcome prospect of carrying it to term" (Armstrong 2005:47). Finally, we must improve the material circumstances of women's lives, and see fetal and maternal interests as interconnected, rather than in oppositional terms, where the fetus is seen as a separate entity to that of the woman carrying it. "The simple fact is that healthy women make

healthy mothers make healthy babies... Moreover, most women are highly motivated to have good birth outcomes. It is time we recognize this powerful truth and provide all women with the means to achieve the goal of health for themselves and their children” (Armstrong 2005:47).

Chapter 6: Suing Mothers for Damages for Prenatal Harm: The Case for FAS

1. Introduction

In this chapter I set out to determine whether and if a child can and should be allowed to sue his or her mother for prenatal harm. I start off by defining what I mean by the term prenatal harm and the reasons why I believe that actions by children with FAS, who have been harmed prenatally through their mothers conduct, should be recognised. I show that although a fetus is not a legal subject in South Africa, this does not mean that a fetus has no value and that we cannot be held liable for causing prenatal harm. In terms of the South African law of delict, a successful delictual action can be instituted against anyone whose wrongful and culpable conduct causes harm to another person. I argue that although a child with fetal alcohol syndrome (FAS) can theoretically sue his or her mother for damages, there are several reasons for why this may not be an effective approach to prevent FAS in children.

2. What are Claims for Prenatal Harm?

Prenatal harm refers to cases where a wrongful act that occurs prior to a child's birth, initiates a causal sequence that leads directly to harm the child (Matthieu 2007, Feinberg 1985; 1984). Joel Feinberg (cited in Matthieu 2007:21) illustrates a case of prenatal harm in the following example: "A negligent motorist who runs over a pregnant woman may cause damage to the fetus that causes it later to be born deformed or chronically ill. Sometime after birth that infant will have an active welfare interest in self-locomotion or health that may be harmed (doomed to defeat) right from the

beginning. The child comes into existence in a harmed state caused by the earlier negligence of a motorist whose act initiated the causal sequence, at a point before actual personhood, that later resulted in the harm. The motorist's negligent driving made the actual person, who came into existence months later, worse off than she would otherwise have been. If the motorist had not been negligent, the child would have been undamaged". Cases of prenatal harm can therefore be understood to refer to those harms that are caused before birth through another's wrongful conduct. Actions for prenatal harm can be distinguished from wrongful life actions. The idea behind wrongful life actions is the controversial "claim that the child has been harmed by being born" (Steinbock & McClamrock 1994) and that his or her existence is such that never having been born would be a preferable condition (Feinberg 1986; Pearson 1997; Strauss 1996; Steinbock 1986). Wrongful life actions are usually brought against physicians, by or on behalf of a disabled child, for being brought into existence. Typically the claim is based on a physician's negligent failure to diagnose his or her impairments prenatally or for failing to have informed the parents of the methods available to screen for fetal abnormalities. "The child argues that "but for the inadequate advice, it would not have been born to experience the pain and suffering attributable to the deformity" (Shandell, Smith & Schulman 2006).

The child therefore claims compensation for being born into an unwanted or miserable life. On the other hand prenatal harm claims are for compensation for what one can term 'wrongful disability'. The issue then is not about whether the "child would be better off dead" (Steinbock & McClamrock 1994) but rather whether the child can sue for having to live with permanent or severe disability. On this understanding, fetal alcohol syndrome (FAS) is a prenatally inflicted harm caused by maternal drinking during pregnancy that affects the born child.

3. Reasons for Recognising Claims for Prenatal Harm

There are several reasons, which relate largely to notions of fairness and equality, for recognising actions for prenatal harm of a child. One reason is that it is largely immune to the charge of unfair discrimination, which typically bedevils approaches that focus almost exclusively on controlling a woman's behaviour during pregnancy or that seek to punish only her. Actions for prenatal harm can be brought by anyone, including fathers. Although this dissertation focuses on women and their role in prenatal harm, men's behaviours and characteristics too can cause prenatal harm. For example, paternal smoking and drinking can result in fetal harm and birth defects because of abnormal sperm (Cicero 1994; Jensen, et al. 2005; Hye Jeong, et al. 2013). Claims for prenatal harm also avoids at least some of the negative consequences such as stigmatisation from having a criminal record and separation from the child due to imprisonment that come with policies that criminalise a woman's conduct during pregnancy. Moreover a policy of allowing a child to sue for prenatal harm is fair to the child in that it seeks to provide compensation to the child for living in the harmed condition, that was caused by someone else's wrongful conduct.

South African courts already recognise delictual claims by parents against third parties whose wrongful conduct caused them harm in some way. Specifically the courts have recognised actions for wrongful pregnancy (or conception) and wrongful birth but have been reluctant to award damages for wrongful life actions²⁸.

Wrongful pregnancy refers to cases where a healthy but unplanned (and therefore in a sense unwanted) child is born following negligent sterilisation or abortion procedure or contraceptive advice by a physician (Pearson 1997; Strauss 1996). In wrongful

²⁸ See for example *Friedman v Glicksman* (1996) and *Stewart & Another v Botha & Another* (2008).

pregnancy parents claim compensation from physicians for the maintenance costs of rearing a child they did not plan to have. In wrongful birth the parents claim compensation, usually from physicians, for the costs of being burdened with a disabled child; something that they claim could have been avoided had they been adequately and properly informed of genetic testing, test results or fetal abnormalities (Pearson 1997; Strauss 1996). In wrongful birth claims, the issue is not that the parents do not want or did not plan to have the child, but rather that they did not want a disabled one. In both wrongful pregnancy and wrongful birth actions, wrongful conduct consists of the prior breach of delict (or contract) which led to the birth of the child and the harm.

A claim for wrongful life was for the first time seriously considered in the case of *Stewart & Another v Botha & Another* (2008). “The *Stewart* case was an action against various medical practitioners whom the mother had consulted with during her pregnancy. The basis of the claim was on the failure of the medical practitioners to inform the parents of the child’s abnormalities that the child presented while still a fetus. The parents of the child further alleged that had the medical practitioners informed them of these abnormalities, the mother would have terminated the pregnancy and the child would not have been born and suffered from these abnormalities. The mother of the child sued in her personal capacity for damages relating to the maintenance, special schooling and past and future medical expenses. The child, represented by the father, brought an alternative claim for the pain and suffering, loss of earnings etc. In essence, the parents sued for both wrongful birth and wrongful life. The medical practitioners argued that there was, in law, no duty on them to ensure that the child was not born and that any claim that recognises such a duty would be contrary to public policy and good morals” (Norton Rose Fulbright

2010). The court awarded damages to the parents for the wrongful birth claim, but refused to do the same for the wrongful life claim on the basis of policy considerations, in particular the controversy of defining birth or existence as a harm and the difficulty of assessing damages for having been born. The court held because the questions raised in wrongful life claims went “so deeply to the heart of what it is to be human, that it should not be asked of the law” (Norton Rose Fulbright 2010). It held that allowing a wrongful life claim would require the court to evaluate and attach a financial value to the existence of a child against non-existence. It further pointed to the negative consequences of recognising such claims in law. It held that allowing wrongful life claims would open the door to claims by children against their mothers in circumstances where she was informed but chose not to terminate the pregnancy, and this could give rise to a situation where medical professionals become overly cautious and advise abortion to avoid possible liability (Norton Rose Fulbright 2010). Although the courts did not recognise the wrongful life claim in this case, it is worth noting the court’s reasoning for not doing so. The difficulty for the court seems to be based on the possible consequences of recognising wrongful life actions and in deciding on how to quantify damages rather than *law per se*.

It seems reasonable to think that if parents can sue others for harm arising from wrongful conduct that children, themselves, should also be allowed to do so against those who wrongfully harm them. Moreover, although the fetus is not regarded as a legal subject under South African law, this does not mean that the law does not seek to protect or promote the interests of fetuses.

4. The Application of the *Nasciturus* Fiction to Promote or Protect Fetal Interests

Currently, in South Africa, legal personality begins at birth, however, the *nasciturus* fiction is a fiction employed to protect the potential interests of an unborn child, and, in terms of which an unborn child can be considered born if it will be to the child's advantage. The result of the application of the *nasciturus* fiction is therefore that the unborn child's interests are kept in abeyance until birth when it becomes a legal subject (person).

The *nasciturus* fiction has been applied in the law of succession and in maintenance law. For example, in *ex Parte Boedel Steenkamp* (1962), the court ruled that the grandchild who was conceived but not born at the time of the grandfather's death could inherit from his estate (unless specifically excluded from inheritance).

The *nasciturus* fiction has also been successfully used to claim maintenance from a third party after the child's birth. In *Chisholm v East Rand Proprietary Mines* (1909), the court recognised a claim for damages against the employer of the child's father after he was killed as a result of a colleague's negligence. The court held that the child is entitled to claim loss of support even though the child was not born at the time of the father's death.

The question of whether a disabled child who was harmed *in utero* as a result of a blameworthy act of a third party should have an action for damages arose in the case of *Pinchin v Santam Insurance Company Limited* (1963). In this case a pregnant woman was seriously injured in a motor vehicle crash and her child was subsequently born with cerebral palsy - a permanent condition resulting in the child never being able to care for himself. In this case the court held that the principles of South African law are flexible enough to extend the *nasciturus* fiction to the field of delict, thus

permitting a child's claim for damages for prenatal harm from a third party (Mankga 2008). The court held that the South African law of delict does not require that the wrongful act and the harm caused by it occur simultaneously (i.e. "that an act and its consequences may be separated in time and space") and that it is therefore unnecessary to invoke the *nasciturus* fiction in delict. It doesn't matter that the harm caused by wrongful conduct in utero would only manifest itself at a later point, i.e. when the child is born, because it is the resulting child that suffers harm as a consequence and who has a delictual action. It is worth noting that in this case the father was unsuccessful in his action because it had not been proved that the brain damage had been caused by the accident. Causation, as will be shown, is a crucial aspect in establishing delict. If there is not a causal connection between harm and conduct the claim cannot succeed.

The general finding in *Pinchin's case* - that a child can have a claim for prenatal harm - was reiterated in *Road Accident Fund v Mtati* (2005). In this case, the father brought an action on behalf of his daughter against the Road Accident Fund for damages that arose as a result of a collision between a motor vehicle that was negligently driven by its driver and his wife, who was a pedestrian at the time of the accident (Mankga 2008). His wife, who was pregnant with the child at the time of the accident, sustained serious bodily injuries, which resulted in the child being born brain damaged. Significantly, in this case the court found it both unacceptable and unjust to deny legal recourse to a child who was *in utero* at the time of the damage-causing event. The court was of the opinion that to deny a child an action in common law, would amount to the child having to go through life disabled through no fault of his own and with no legal recourse.

5. Choice on Termination of Pregnancy Act and Fetal Interests

Aside from the application of the *nasciturus* fiction, there are other instances where the law has sought to protect the interests of the unborn, even though it may not have legal rights prior to birth. For example it is clear that while the Choice on Termination of Pregnancy Act (No 92 of 1996) affords women the right to abortion that the right is qualified in several ways namely, in terms of when and how it can be done, for what reasons and by whom. One thing that the Act reveals is a gradual shift towards fetal protection as the fetus develops. After the first 12 weeks of pregnancy, certain conditions must be met before a woman can qualify for an abortion.

These conditions imply that as the pregnancy progresses a woman's freedom of choice or right to abortion becomes limited; even to the point that the decision must somehow be endorsed by a medical practitioner. The constraints to a woman's right to abortion suggest that the right is not absolute thus that the state considers prenatal life an important value in society that sometimes may need to be balance with a woman's autonomy or rights (Meyerson 1999).

So far I have proposed that the principles of South African delict can and has accommodated the *nasciturus* fiction but that it is not necessary to invoke the fiction in delictual actions because the law of delict does not require that the wrongful act and the damage caused by it occur simultaneously. This suggests that a disabled child who was harmed as a consequence of another's wrongful and culpable act while in utero can theoretically sue for damages provided that the elements of delict are established.

6. Overview of South African Law of Delict

The law of delict sets out the broad principles or elements in terms of which a person who has suffered harm at the hands of another may claim compensation (Loubser & Midgley 2009). Delict has been defined in different yet shared ways. Neethling, et al (2006) define it as “an act of a person that in a wrongful and culpable way causes harm to another,” (Neethling, et al. 2006) whereas Van der Walt & Midgley (2005) define it as a wrongful and blameworthy conduct by a person which causes monetary loss, bodily injury, or injury to a personality interest of another person. And David McQuoid-Mason (2011) defines it as the breach of a general duty imposed by the law, and not one based on a contractual relationship between the parties.

Delictual duties, then, are those duties owed to people generally and not to a particular group of people with whom we have contractual relationships. If one breaches a duty that one has *voluntarily assumed* then this is a breach of contract. Remedies for breach of contract are primarily directed at enforcement, fulfilment or execution of the contract, whereas delictual remedies are directed at compensation and not fulfilment.

The basic delictual actions that can be instituted by a person who was legally wronged and who is able to satisfy the conditions of delict are the Aquilian action, the action *iniuriarum* and an action for pain and suffering (Breetzke n/d). The Aquilian action is a broad action with which both general and special patrimonial (monetary) damages, caused by culpable conduct can be claimed, whereas the *actio iniuriarum* is used to claim for intentional injury to one’s personality. The action for pain and suffering can be used where “the impairment of a person’s personality was caused by negligent conduct” (Breetzke n/d). The three possible actions that a plaintiff can institute against the defendant are not mutually exclusive, so people, who suffer different kinds of

harm at the same time, can simultaneously claim compensation under more than one action.

7. Elements of Delict

A person is legally wronged, if he or she can prove the following five required elements of a delict, which is, per definition, an unlawful act (Loubser & Midgley. 2009; Neethling, Potgieter & Visser 2006; Van der Walt & Midgley 2005):

- (i) Conduct
- (ii) Wrongfulness
- (iii) Fault (blameworthiness)
- (iv) Causation
- (v) Harm

7.1. Harm

The purpose of a delictual action is to enable a plaintiff (aggrieved party) to claim compensation from the defendant (alleged wrongdoer) for the harm caused. Thus the plaintiff must prove that he or she suffered harm as a result of the defendant's conduct. A plaintiff may claim for patrimonial (e.g. medical expenses) and non-patrimonial damages (e.g. pain and suffering).

7.2. Conduct

The defendant's conduct must have been voluntary; it must not have been coerced or be the result of uncontrollable muscular actions, as in for example the case when a person having an epileptic fit may hit another person. Delictual conduct includes

positive actions (commissions) or actions by omission (i.e. a failure to do or say something) and statements.

7.3. Wrongfulness

There are two aspects to wrongfulness: (i) the act must have caused the harmful result, and (ii) the act must have taken place in a legally reprehensible or unreasonable manner. If a harmful result did not occur then the act is not wrongful. Thus not all harms are per se wrongful in the sense that it will incur liability in law. In order to succeed with a delictual action, the plaintiff must prove that the defendant infringed upon his or her subjective right(s) or failed to adhere to a legal duty. A subjective right is a protectable interest which a legal subject (e.g. a person) has. If one has a valid defence e.g. consent, self-defence, provocation or necessity, then one's behaviour is not wrongful.

In the case of omissions, liability arises only in special circumstances (Loubser & Midgley. 2009; Neethling, Potgieter & Visser 2006; Van der Walt & Midgley 2005), if one had a duty to prevent harm to the plaintiff.²⁹ This means that “a legal duty rests on the wrongdoer, to prevent the potential danger from becoming a real danger” (Breetzke n/d). A failure to fulfil this duty constitutes loss or damage to another person. The generally accepted omissions which give rise to delictual liability include instances where:

- (i) One “creates a potentially dangerous situation and fails to remove the danger” and it “results in loss or damage being caused” (Breetzke n/d).
- (ii) One fails to exercise control over a potentially dangerous object or animal.

²⁹ For example it would be wrong for a lifeguard tasked with saving people from drowning to not attempt a rescue, whereas there may be no duty on an ordinary person to attempt a rescue of a drowning stranger.

- (i) “Positive action” is “required by statutory provision” (Breetzke n/d).
- (ii) A “special relationship” “exists between the parties” (Breetzke n/d).
- (iii) The harm is foreseeable (Loubser & Midgley. 2009; Neethling, Potgieter & Visser 2006; Van der Walt & Midgley 2005).

A general “duty of care may be considered a formalisation of the social contract, the implicit responsibilities held by individuals towards others within society”. To establish wrongfulness, the plaintiff must show that a duty of care exists and that the duty was breached. A breach of duty exists only if the defendant failed to act as a reasonable man would have done under the particular set of circumstances.

7.4. Causation

For a delictual action to be successfully established it is also necessary to prove a causal link between the wrongful action and the harm suffered. If this link is missing then the defendant cannot be held delictually liable.³⁰ Law differentiates between factual causation and legal causation. Legal causation presupposes factual causation so it is necessary to first prove factual causation. Factual causation is proved by a demonstration that the wrongful and culpable conduct was a cause of the harm (*Minister of Police v Skosana* 1977). This is also known as the “but-for” test. In terms of this test, “If the wrongful conduct is take out of the equation, and the result also falls away”, then a factual causal nexus/link exists between the act and the result” (Breetzke n/d). A successful demonstration of factual causation is however not necessarily enough to result in legal liability. Legal causation must also be proved. “Legal causation seeks to limit the consequences of the unlawful act to what can be

³⁰ See for example *Mtati*’s case, discussed above.

regarded as reasonable” (Breetzke n/d). This means that the wrongful and culpable conduct must be linked sufficiently close to the harm for delictual liability to ensue.

7.5. Fault

In order to establish a successful delictual action, the plaintiff must also prove that the wrongful conduct is blameworthy (culpable), in other words “that the person who committed the wrongdoing can legally be blamed for his conduct” (Breetzke n/d). This requires that he “possess the necessary mental capacity to distinguish between right and wrong and be able to act accordingly. A subjective test is applied each time, in that each case is judged on its own facts and merits, and each person’s abilities are judged in order to determine whether he” or she “can legally be blamed for the conduct” (Breetzke n/d). Fault can take one of two forms, viz. intent or negligence.

7.5.1. Intent

Intention concerns the defendant’s state of mind. Conduct is intentional if a person directs his or her will at achieving a particular result while being aware of the wrongfulness of the conduct. This means that one must both intend to injure and know that it is wrongful (*Maisel v Van Naeren* 1960). Intention is different to motive. Whereas intention concerns *how* the act was performed, motive concerns one’s reasons for acting, in other words *why* the act was performed. Intention may take one of three forms:

- “*Dolus directus*, where the wrongdoer directed his will at achieving a particular result;
- *Dolus indirectus*, where the wrongdoer proceeds to act, despite being aware of or sure of the fact that a certain consequence will invariably follow;

- *Dolus eventualis*, where the wrongdoer foresees the possibility that a certain consequence might follow, but proceeds to act in spite of this” (Breetzke n/d).

There are several defences that exclude intent, including if the person is a youth or is emotionally and intellectually immature (*Weber v Santam Insurance Co* 1983), suffers from mental disease or illness (*S v Campher* 1987) or is ignorant (*Maisel v Van Naeren* 1960). Consent (*Jordan v Delarey* 1958), self-defence (*S v Van Wyk* 1967), provocation and necessity (*S v Pretorius* 1975; *Stoffberg v Elliot* 1923) are additional factors that may exclude one from liability.

7.5.2. Negligence

Not all wrongful conduct is intentional. “Where a person’s conduct does not conform to the standard of conduct which could legally be expected of him in those specific circumstances, his conduct is negligent” (Breetzke n/d). In order to prove that the defendant acted negligently, the aggrieved party must establish that the defendant acted differently from how a reasonable or average person would have in the same set of circumstances. It must be shown that the reasonable person would have foreseen that the behaviour risks harming others and subsequently have taken steps to prevent the harm from materialising (*Kruger v Coetzee* 1966; *Lomagundi Sheetmetal and Engineering v Basson* 1973) or at least seek to minimize it.

The idea behind negligence is that people should exercise a reasonable standard of care when they act. “Conduct can only be negligent if it is certain that the reasonable person would have acted differently in the same set of circumstances” (Breetzke n/d).

This means that people should foresee the likely consequences of their actions for others and avoid those which are unreasonably harmful to them. The requirement to exercise reasonable care is an objective standard based on an average or reasonable

person. It does not require perfection on one's part, or that one foresees every eventuality and prevents all kinds of risks to others. The duty to exercise reasonable care when acting is breached when someone who engages in conduct that poses an unreasonable risk toward others and/or their property that actually results in harm. Equally, a person who knowingly places others at a substantial risk of harm, which any reasonable person in the same situation would clearly have realised also breaches that duty of care.

In certain cases a modified version of the reasonable person test is applied. This is because the ordinary application of reasonable person test might lead to unfairness. For some individuals and groups the reasonable man standard would be low and lead to situations where the wrongdoer is absolved of wrongdoing. This explains why we posit a higher standard for experts and expect the "to act with a greater degree of care and caution than the reasonable man" (Breetzke n/d).

On the other hand, there are persons for whom the reasonable man standard is too high and demand extraordinary behaviour from ordinary people. This explains why we generally treat mentally incompetent and not fully competent people differently and not hold them to the standard of the reasonable man as a rule. Generally, "children are tested according to the standards of the reasonable man, provided that the child has the required accountability and is able to distinguish between right and wrong and act in accordance with that knowledge" (Breetzke n/d).

8. Can Children with FAS Successfully Sue Their Mothers for Compensation?

Given the above analysis of the elements of delict required for the successful establishment of a delictual action for prenatal harm, it seems theoretically possible

for a child with FAS, and to a lesser degree for its less severe forms, to sue his or her mother for damages³¹. The focus of this discussion will therefore relate primarily to FAS.

Conduct is established if the woman voluntarily drank during pregnancy. Essentially voluntariness of choice and action is established if it can be shown that the woman had options from which to choose; that her decision to, and act of drinking was not forced on her. Typically, the influence of alcohol upon a person's mental capacity may result in a temporary loss of active legal capacity (*Van Metunger v Badenhorst* 1953); however, this exception does not seem applicable in the case of FAS. It is worth noting that under South African law, drunkenness is no excuse for driving a motor vehicle while under the influence of alcohol. Even though a drunk driver may not intend to kill a pedestrian on the drive home, when he or she does, they are still brought to justice. The law does not discriminate between its treatment of alcoholics and non-alcoholics. Alcoholism and drunkenness do not therefore seem to excuse a woman's conduct from voluntariness because her initial decision to drink was voluntary, in the sense that she could still choose whether or not she will drink alcohol. A woman's addiction to alcohol may make her decision reckless, and the decision to abstain difficult, but her decision to drink can still be voluntary because she could opt to act otherwise. Just as she is free to drink, so she is free to abstain. It seems absurd to claim that women can choose to drink based on respect for her autonomy (right to self-determination), but not to think that they are equally capable of choosing not to do so.

³¹ It must be borne in mind that some of the features used to diagnose ARBD (alcohol-related birth defects) and ARND (alcohol related neurological disorders) are not exclusive to prenatal alcohol exposure, as has been shown in Chapter 2. For these diagnoses it is less clear that prenatal alcohol exposure is a factual causal factor of the harm.

Concerning harm, the child exposed to alcohol prenatally can suffer a range of conditions; FAS being the most severe condition that result in a range of primary and secondary disabilities in the child. Although there is uncertainty about the exact timing, dosage and frequency of alcohol exposure that actually causes harm, and the fact that a range of variables influence the risk for FAS, FAS is entirely preventable if a woman abstain from alcohol if she plans to become or is pregnant and plans to continue the pregnancy. Precisely how much alcohol during pregnancy is unsafe is contentious, however given the uncertainty about any potential safe level of drinking during pregnancy it seems prudent for pregnant women who intend continuing a pregnancy to abstain in light of the risks. Prenatal alcohol exposure is a factual cause of FAS. But just like a gun can't shoot by itself so alcohol cannot make people drink. People choose whether or not they will drink. If it can be proved that a woman was unreasonable in her decision to drink during pregnancy and that her wrongful conduct caused harm, then legal causation can be established.

While it may be the case that many women are not aware of the dangers associated with drinking during pregnancy, information about the hazards of drinking during pregnancy is arguably generally available in South Africa, so there seems to be little good reason for thinking that women are ignorant or don't know that drinking during pregnancy is potentially harmful to one's child. In addition to general public health promotion efforts, mandatory warning labels on alcoholic beverages in South Africa serve to give consumers information about the risks of drinking during pregnancy.

Nowadays, in terms of the *Regulations to the Foodstuffs, Cosmetics and Disinfectants Act* (1972), container labels for alcoholic drinks must contain one of seven health messages or warnings that includes one that reads "Drinking during pregnancy can be harmful to your unborn baby". Moreover, in terms of the *Guidelines for Maternity*

Care in South Africa (Department of Health 2002), all health workers (not only midwives and obstetricians) who care for women in the reproductive age must identify women at risk of alcohol abuse or having a FAS baby and offer them counselling and refer pregnant women at risk for having a child with a birth defect or genetic disorder as early as possible in the pregnancy for counselling regarding management and the performance of prenatal tests.

The right to terminate a pregnancy implies a right to choose to become pregnant and have a child. In South Africa women have a right to terminate a pregnancy, by implication one can infer a decision to continue a pregnancy as a commitment to a general duty of care towards her fetus and consequently future child. A special relationship exists between the pregnant woman and her fetus; they are uniquely intertwined; distinct yet also connected. A fetus is dependent on her for its continued existence, making it especially vulnerable. Whatever the woman does affects not only herself but also her fetus.

When a woman chooses to continue a pregnancy, she is typically considered a prospective mother and her fetus, a future child; one likely to be born under normal circumstances. Generally the social expectation is that she behaves in ways that benefit a fetus; that she takes reasonable steps to promote and safeguard its interests from harm. As a prospective mother she is not just a pregnant woman but now one that stands in a special relationship with not just a fetus but her future child, to whom she has concomitant responsibilities.

It is also worth noting that even though the decision to abstain from alcohol may be hard, a woman can seek help. Moreover, abstinence (the sacrifice she is required to make for the sake of her child) will not be lifelong, only 9 months, after which time she can resume drinking. When considering the longer-term benefits and short-term

costs of abstinence, it seems that a reasonable woman would and should abstain. If she chooses to drink during pregnancy she arguably breaches her duty of care towards her fetus. Even though her intention may not be to harm her fetus (and child), but for example wanting to satisfy a desire to drink, she can still be found negligent, for choosing to do so and for not taking reasonable steps to prevent harm to her fetus.

The above analysis suggests that a child who was exposed to alcohol prenatally and consequently born with FAS has suffered harm, in that he or she will have to go through life with physical and cognitive disability. The child has not only been harmed, he or she has also been wronged, because he or she was put into a disabling condition that was preventable and required only a reasonable and time-bound change in behaviour on the mother's part. My view is therefore that a child with FAS can theoretically institute a delictual action against his or her mother.

9. Should a Child with FAS Be Allowed to Sue Its Mother for Prenatal Harm?

There are good reasons for recognising prenatal actions by a child with FAS. It seems both fair and reasonable, particularly in light of the fact that parents can claim damages from third parties for prenatal harm. However, there also reasons that undermine the effectiveness of this approach. While it makes sense to hold third parties liable for prenatal harm, holding the child's mother legally responsible in this way does not obviously seem to resonate with our common sense conceptions of the mother-child relationship. Society does not expect mothers to do absolutely everything all the time to ensure that their unborn children are always benefitted and never harmed. Society understands that the duty of care require that she act as a reasonable mother would, as average people are thought to. No parent is required to

do absolutely everything for the sake of their children. Society recognises that they may have other, sometimes weightier duties such as duties to oneself or duties to others. For example a pregnant woman who has cancer may have to decide about whether to take treatment that will benefit her but is harmful to her fetus. Permitting prenatal actions against mothers has the effect of requiring women to always absolutely act in the interests of the fetus. Where she has to choose between her duties to herself or others and those to her fetus, she must choose those to her fetus. This would however create an unreasonable burden on pregnant women, since even their most mundane actions could cause prenatal harm and render her delictually liable. Arguably, prenatal harm actions against mothers would infringe too much on her rights of privacy and bodily autonomy.

Another reason why recognising prenatal actions against mothers is problematic was raised in *Stewart's* case (2008). In this case the court held that recognising wrongful life claims would open the door to claims by children against their mothers in circumstances where she was informed of the abnormality but chose not to terminate the pregnancy. This situation, the court held, could give rise to a situation where medical practitioners become overly cautious and advise abortion to avoid possible liability. Equally, a pregnant woman who fears that her child could or may sue her for prenatal harm might choose instead to have an abortion.

A final concern is more pragmatic in nature. Women at risk of having a child with FAS are typically poor. Even if a child lodged a successful claim, it is unlikely that the mother would be able to afford to pay damages. The actions are essentially empty if the child cannot be compensated.

10. Concluding Remarks

This chapter sought to determine whether a child with FAS can generally sue his or her mother for prenatal harm. I offered reasons for why prenatal harm actions by a child can and should be recognised. Even though recognising and permitting such actions may be detrimental to the mother-child relationship, the concern seems misplaced, for as Mathieu (2007:141) notes, “it is not the legal system’s recognition of legitimate claims for compensation that creates difficulties within a family, but the other way around - that is, the existence of serious family strife leads one member to seek compensation from another through the courts.” Whether consequentialist considerations should outweigh considerations of fairness is debatable. To deny children who have been harmed prenatally a right to sue for damages would be to tantamount to unfair discrimination, because our law already recognizes prenatal harm claims as legitimate causes for legal action. Thus, denying a child who has been harmed prenatally a claim would be to deny him or her equal protection of the law.

Chapter 7 - Conclusion

This dissertation focused on the topic of moral responsibility for prenatal harm. It set out to achieve several interrelated goals aimed at considering the moral responsibility of pregnant women and the state concerning FAS, as a paradigm case of preventable prenatal harm.

The first two goals of the dissertation were to establish the moral implications of both becoming pregnant and choosing to carry a fetus to term and to establish the set of moral obligations that prospective mothers may have toward their future children.

I propose that women choose to continue a pregnancy when they have the option of terminating their pregnancies and that they are prospective mothers when they do so, to distinguish them from pregnant women who choose to terminate their pregnancies.

I argued that prospective mothers have *prima facie* moral obligations not to harm but to benefit their future children. I argued that a prospective mother's right to do as she pleases is limited by the principle of parental responsibility, which posits an obligation on her to take into consideration, if not, act in the best interests of her future child. I suggest that this implies a responsibility on her to alter her lifestyle for the sake of her future child, but that this responsibility must often be balanced with her other obligations, and hence cannot be an absolute one that requires her to always prioritise the interests of her future child.

I argued that women have a general obligation to stop drinking if they are pregnant and choose to continue it to term. I suggest that alcoholics can have moral responsibility and that alcoholism does not diminish one's capacity for moral

responsibility, but that the duty to abstain from alcohol if one is pregnant cannot be an absolute one. To require women to refrain from all behaviours which is potentially harmful to their future children, would be unreasonable and unfair and essentially paralyse them into inactivity. Many related factors serve to complicate the establishment of a definitive link between drinking during pregnancy and FAS, and thus make it difficult to posit an absolute obligation on her to stop drinking. Moreover, it seems unreasonable to expect women alcoholics to simply abstain if they are pregnant. However, even though women do not have absolute obligations to prevent harm to future children, this does not mean that we cannot and do not still judge their behaviour to be (ir-) responsible.

The third and fourth goals of the dissertation were to investigate society's interest in the issue of FAS and how it ought to be protected and/or enforced. I argue that, even though women have general obligations to prevent FAS in their future children, they cannot be held solely responsible. FAS does not come into existence, nor does it thrive, in a social vacuum. FAS can be seen as a social disease with roots in social practices and beliefs that are morally deeply problematic. Many factors that influence a woman's decision to drink have to do with her psycho-social and economic circumstances, including alcohol's widespread availability and social acceptability, suggesting a social responsibility for FAS. In an attempt to show society's interest and justify a social response, I offered evidence of the social and economic impact of maternal drinking and FAS. I then considered what an ethically appropriate social response to prevent FAS would entail. In so doing I evaluated the morality of policies that aim to punish women who drink during pregnancy, in an effort to prevent FAS. I argue that policies that criminalise a woman's conduct during pregnancy are unjustified and likely to be ineffective. I propose interventions that may constitute an

ethical social response to FAS prevention and consider some of the relevant policies in South Africa that deal with drinking during pregnancy, alcohol abuse and FAS.

The fifth and final goal of the dissertation was to establish if and whether children with FAS can and should be allowed to institute delictual actions for prenatal harm against their mothers. Following reflection on common law on the status of the fetus, provisions of the *Choice on Termination of Pregnancy Act* (1996) and the principles of delict under South African law, I argue that children can theoretically sue their mothers and that they should be allowed to do so, but that even this may not be an effective approach to FAS prevention.

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